MEDICAID DEMONSTRATION PROJECT
FOR LOS ANGELES COUNTY

EXTENSION PROPOSAL

OCTOBER 1, 1999

MEDICAID DEMONSTRATION PROJECT FOR LOS ANGELES COUNTY
1115 WAIVER EXTENSION PROPOSAL
FISCAL YEARS 2000-2005

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EXECUTIVE SUMMARY

This is a request to extend the Medicaid Demonstration Project for Los Angeles County ("1115 Waiver," "Waiver," or "Demonstration Project") for five years to continue the transformation of the second largest County health care system in the nation.

INTRODUCTION

At the start of the 1995-96 fiscal year, Los Angeles County was faced with an unprecedented $655 million budget deficit in health services—the loss of one out of every two dollars available—and a devastating collapse of the safety net. In response, State, Federal, and County officials intensively collaborated to develop a five-year Medicaid Demonstration Project to address the County's structural and financing crisis by helping to stabilize the County Department of Health Services ("DHS") system, and, over time, move it away from expensive hospital services toward community-based primary and preventive care services.

DHS has made notable progress toward meeting the Demonstration Project goals. However, the fundamental restructuring goals of reducing inpatient and expanding outpatient care cannot be fully met by the end of the current Project term, June 30, 2000. The County's considerable progress cannot be sustained unless the structural and financial problems which contributed to the original fiscal crisis are addressed. Continued State, Federal and County collaboration is needed to address the underlying problems confronting the County, which have not been resolved, including:

Welfare Reform and Declining Medi-Cal — After more than twenty years of steady growth, the number of Medi-Cal eligibles has declined throughout the State. For example, the number of Medi-Cal eligibles in Los Angeles County has steadily decreased from 1.9 million to about 1.7 million since 1995. Between January 1996 and January 1998, the number of AFDC/TANF cases in Los Angeles County decreased by 23%. Major studies demonstrate that welfare reform has been a significant factor in the decline in Medicaid enrollment.

Shift of Medi-Cal Population/Reliance on Safety Net —The County public hospital system has lost 132,000 Medi-Cal inpatient days, a 26.1 percent drop, since FY 1994-95. This has serious implications for the County's health care system, which provides over 85% of all uncompensated care in Los Angeles County. Because the County relies heavily on revenue from inpatient hospital services, these reductions jeopardize the continued ability of the health care safety net to serve both Medi-Cal and indigent patients.

Limited Success of Expanding Insurance Coverage — Despite recent improvements to expand insurance coverage to children at the Federal and State levels, these do not offset the annual declines in Medi-Cal coverage and the low rate of job-based insurance. The uninsured rate for children has not changed significantly; even under the "best case" scenarios there would still be more than 300,000 children uninsured.

Large and Rising Uninsured — The uninsured population has steadily increased despite a rebounding local economy. Most estimates indicate that the highest job growth has been in low-wage jobs that typically do not offer health insurance coverage. Thus, the uninsured population is expected to continue to rise. Over the past two years, the County has averaged about 150 new uninsured persons per day.

Continued financial incentives for inpatient and emergency services — Despite the program changes that have reduced inpatient and inappropriate emergency services, very little net savings to the County have resulted due to loss in Federal and State revenues. The current Medi-Cal funding mechanisms create a "Catch 22" for County DHS. Progress toward the County's restructuring goals does not produce the significant financial savings necessary to maintain the changes.

Limits in Payments to Safety Net — Even with 1115 Waiver funds, the total federal funding available to County DHS has declined from $1.2 billion to $1.1 billion since the beginning of the Demonstration Project. The proportion of the DHS budget composed of federal funds has dropped from 50 percent of total funding to 47 percent. The Disproportionate Share Hospital program is scheduled to decline by 19% in FFY 2002, based on the Balanced Budget Act of 1997 (BBA). Moreover, the elimination of Federal cost-based reimbursement for Federally Qualified Health Centers, relied upon by many of the County's private partners, is proceeding in phases and will end after FFY 2003.

JUSTIFICATION

An extension is justified because:

- Although the County has made a fundamental shift in the delivery of health

care, more work is needed to achieve the complex and difficult process of restructuring. Major goals of the Demonstration Project have not yet been fully accomplished. While the County has demonstrated a firm commitment to change, restructuring that expands ambulatory care, integrates public and private partners, and changes long-standing clinical practices requires additional time.

- Continuation of the current Project funding and the addition of the Healthy Students Partnership, Workforce Retraining and other requested funding components will provide the funding flexibility necessary to support progress toward community-based primary and preventive care services and the implementation of inpatient efficiencies.

- Continuation of the Demonstration Project will allow the County to build on the initial phase of stabilization and structural changes to improve the management of diseases for at-risk-Medicaid and the indigent population.

- Los Angeles County has a disproportionate share of the nation's working uninsured—twice the nation's rate. The total number of uninsured is projected to be 3 million by the year 2005. In the absence of national health policy reform, the Demonstration Project provides the vehicle for the federal government to assist the County in responding to the financial pressures on its health care system brought about by the expanding uninsured population and to maintain the safety net that serves Medicaid beneficiaries and the indigent.

- The aggressive expansion of managed care and the reduced revenue associated with low capitation payments strain and reduce the resources of those safety net providers that serve substantial number of Medicaid eligibles and serve as the last resort for the uninsured.

- Public schools must become a partner in the emerging public and private delivery system to better serve the children eligible under Medicaid and the State's Children's Health Insurance Program (i.e., "Healthy Families"). This will expand access to ambulatory care, provide a nexus for increased enrollment in the Medi-Cal and Healthy Families programs, and improve the health status of children and youth where they are—in school.

- A labor-management initiative that retrains and prepares the workforce that serves both Medicaid and indigent populations is essential to sustaining the ongoing restructuring under the Project. As the County system undergoes dramatic changes, it needs a workforce prepared for new responsibilities with new or enhanced skills responsive to the dynamic health care environment.

- Increased demand for specialty services, a consequence of the expansion of primary care, needs to be accommodated.

Without continuation of federal assistance through a Waiver extension and new amendments, accomplishments to date could be jeopardized and emerging opportunities will not be realized. Approval of this request would reaffirm the initial commitment of the Federal government to the restructuring of the County's health care system, and incorporate new strategies consistent with existing efforts.

MAJOR RECOMMENDATIONS

The restructuring process requires fundamental changes throughout the County's health care system. The County has demonstrated its deep commitment to making the necessary changes. However, once the changes are made, they must become institutionalized in policies and in the behavior of individuals throughout the system, from County employees to public/private partners. A continuation of the Demonstration Project will support this effort through the following elements:

A five-year extension of the core financing elements in the existing Terms and Conditions, enabling the Department to:

- Support and continue the restructuring efforts achieved through June 30, 2000.

- Advance integration of public and private health services for the indigent and Medi-Cal populations.

A Restructuring/Stabilization Program that changes financial disincentives to invest in ambulatory care expansion and disease management interventions that can ultimately reduce the burden of disease. The recommended fiscal amendments would enable the Department to:

- Expand community-based ambulatory care services by 900,000 additional visits through public and private providers to reach the initial target of 3.9 million.

- Reduce by another 10 percent the inappropriate utilization of inpatient care.

- Implement a new approach that is not solely geared to reducing beds, but also managing diseases more effectively. The implementation of disease management programs for pediatric asthma, diabetes, congestive heart failure, HIV/AIDS, and other selected diseases, will decrease resource consumption, change clinical practices, and improve the health status of patients.

- Expand community-based risk reduction programs for high-risk families and individuals to reduce reversible risk factors for common diseases and injuries, including tobacco, alcohol, drug abuse, poor diet, sedentary life style, and violence.

- Gain flexibility in obtaining disproportionate share hospital ("DSH") revenues to enable County DHS to receive a one-to-one replacement of DSH dollars lost from inpatient reductions by increasing Supplemental Project Pool funds available for ambulatory care under the Waiver.

- Gain State and HCFA approval of budget neutrality limits based on: (1) FY 1999-2000 budget neutrality limit, (2) carryover of budget neutrality savings expected under the current Waiver (as was granted for Oregon), and (3) non-DSH Medicaid inflation rate factor of 8.4% per year.

- Engage the State and HCFA in identifying/developing funding mechanisms to realize additional revenues allowed under renewed budget neutrality limits.

- Institutionalize funding arrangements to the extent that successful program changes demonstrate efficient use of resources.

An amendment to fund the Healthy Students Partnership program for school-based and school linked services with public school districts, enabling:

- Expansion of ambulatory care services, targeting uninsured school-age children and youth, for a projected 500,000 annual visits by 2005.

- Linkage of schools with the emerging public and private health care delivery system of DHS clinics and partners to secure more effective outreach, health promotion, enrollment in Medi-Cal and Healthy Families, and coordination of care.

An amendment to fund an essential multi-year Health Care Workforce Retraining Project based on the recommendations by the *President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry*. This project would:

- Design and implement workforce training and retraining programs for an estimated 2,400 workers at immediate risk due to restructuring.

- Retrain employees to change organizational culture and accelerate transition towards an integrated delivery system, guided by public health principles, and facilitated by a strategic alliance between management and SEIU Local 660.

- Assure a properly staffed delivery system for Medi-Cal beneficiaries and the indigent.

An amendment to provide specialty care services at public hospitals to medically indigent patients, enabling the Department to:

- Support the changing role of public hospitals in the coordination and provision of 250,000 added specialty care visits above the current level of services.

- Reduce waiting times to less than 21 days for high-demand specialty care services (as a result because of expanding access to primary care).

THE FIRST FIVE YEARS: CHARTING A NEW COURSE

During the current five-year Demonstration Project, the County has shifted the direction of DHS and achieved notable progress in key areas, including:

Expansion and Restructuring of Ambulatory Care Capacity and Access

- Increased ambulatory care sites throughout the County, from 45 to 149 sites, through a new Public/Private Partnership ("PPP") program with safety net and traditional providers.

- Increased ambulatory care visits by 600,000 after stabilization, mostly for primary care services.

- Decreased inappropriate use of the emergency room by 27%.

- Established specialty care referral centers to coordinate care for the medically indigent patients referred by DHS and PPP providers. (Long appointment waiting times for specialty care continues to be an issue for DHS.)

- Developed an innovative set of ambulatory care indicators to assess the full extent of increased access, including nurse encounters, home health visits, telephone contacts, nurse triage, etc.

- Initiated a comprehensive, community-based health planning process, involving over 400 participants and using data from the L.A. County Health Survey, that produced the County's first Ambulatory Care Plan approved by the Board of Supervisors in February 1999.

- Established the Office of Ambulatory Care to develop policies that increase access to cost-effective ambulatory care services and effective health promotion and disease prevention programs.

Reduced Inpatient Services

- Decreased budgeted beds by 28%—five times higher than the State trend and three times the national trend.

- Decreased average daily census by 24%—five times higher than the State trend and three times the national trend.

- Reduced average length of stay from 6.4 days to 5.9.

Improved Cost Management

- Reduced expenditures, including staff for hospital services in the County DHS public system, by $123 million from FY 1994-95 to FY 1997-98.

- Reduced the annual federal funding levels by an average of $174 million, even with the inclusion of Demonstration Project funds, through FY 1998-99.

- Projected savings of $408 million in federal revenues below the budget neutrality limit.

- Reduced the workforce by 15 percent, a decrease of 4,300 employees (permanent and temporary workers) and 2,500 layoffs, between October-November 1995 and July 1998.

- Began a system-wide reengineering process with savings targets of $40.7 million for FY 1998-99.

Forged New Community Initiatives

- Initiated the Healthy Students Partnership process with public school districts, targeting uninsured school-age children. Implementation of this program is expected to result in 500,000 ambulatory care and prevention visits.

- Developed a cooperative project with SEIU Local 660, partially funded by a $1.2 million grant from the US Department of Labor, to plan for the retraining of workers at-risk due to restructuring.

- Developed a system-wide workforce and diversity training program.

- Established the Office of Women's Health to develop policies and programs that improve the health status of women.

- Began a series of initiatives to improve the health status of children, such as the Healthy Students Partnership, the first Children's Health Policy Summit, and a set of priority "Interventions for Children 0-5" years of age.

- Conducted a countywide health survey to document a profile of the insured and uninsured, and their health status—with results reported in a new periodic DHS publication, *L.A. Health*.

- Incorporated survey data into the community-based planning process.

Expanded Managed Care

- Increased the enrollment of Medi-Cal members in the County's HMO, CHP, from 14,000 to approximately 95,400 lives as of March 1999.

- Earned State designation for two consecutive years as the preferred "Community Provider Plan" in Los Angeles County for Healthy Families—California's SCHIP program.

GOALS NOT YET MET

Although substantial progress has been made, major objectives during the first five years were not fully accomplished and require additional time, including:

- Achieving the ambulatory care access objective of increasing access by 50%. The Department has not yet met the initial target of 3.9 million visits.

- Implementing cost efficiencies and service consolidations. The initial reengineering targets were unrealistic. A revised target to save $82 million annually by FY 2000-01 has taken into consideration the complex issues of system-wide implementation.

GENERAL LESSONS LEARNED

The first years of the Demonstration Project provide several significant lessons to guide the process for the next five years. These include:

- Privatization demands adequate reimbursement for uncompensated care.

- Public/private partnerships are effective in increasing ambulatory care access.

- Increased access is more than increased number of visits. It includes other cost-effective methods such as nurse encounters, home health visits, telephone contacts, nurse triage, etc.

- Reforming a health care system requires broad participation from community, labor, and other stakeholders, with an emphasis on reducing the burden of disease.

- Appropriately assessing the special circumstances of large public teaching hospitals is a necessary part of developing benchmarks and determining any potential revenue impacts.

- Fiscal reform will be essential to advance community-focused restructuring.

THE NEXT FIVE YEARS: MANAGING DISEASE AND PATIENT CARE

The next phase in charting the new course is rooted in the general lessons learned during the current Demonstration Project period. It involves (1) a continuation of the structural changes already underway, (2) realization of expanded ambulatory care services to the medically indigent, and (3) a concerted effort to reduce the burden of chronic disease through patient/disease management and disease prevention. These combined efforts are reflected in the following strategies and objectives outlined for the next five years. These include:

Further Increasing Access

- Meet the initial target of 50 percent increase in access by delivering 900,000 additional annual visits through public and private partnerships by 2004-2005.

- Implement Healthy Students Partnership, targeting uninsured school-age children—resulting in 500,000 additional visits by 2005.

- Expand specialty care services by 250,000 additional annual visits by 2005.

- Enhance the mix of services through cost-effective methods that serve uninsured patients relying on the safety net system.

    - Expand home health services by at least 50%
    - Increase telephone encounters (including pharmacy) by at least 50%
    - Increase nurse only visits by at least 50%
    - Increase referrals by at least 50%

- Create a community assistance program under the Office of Ambulatory Care to inform consumers and stakeholders, respond to community concerns, and focus on other areas of improvement.

Managing Disease

- Reduce by 10 percent the number of preventable hospitalizations in each acute care hospital by implementing disease management programs for:
    - Pediatric Asthma
    - Diabetes
    - Congestive Heart Failure
    - HIV/AIDS
- Reduce the number of inappropriate emergency room visits by an additional 10%.
- Expand community-based risk reduction programs for high-risk families and individuals.

Service and Quality Improvement

- Improve the performance of safety net systems for Medi-Cal and uninsured populations through enhanced monitoring of networks, contracts, and service standards.
- Improve quality assurance programs based on a consumer-driven and continuous service/quality improvement process. The biannual L.A. Health Survey and the current patient survey being conducted by UCLA will help in assessing the effectiveness of a "restructured system," focusing on major areas of care.
- Invest in planning and evaluation functions to ensure integrated networks of public health and managed health care services that meet the health needs of communities.

New Initiatives

- Increase the focus of graduate medical training programs on primary care based on the newly negotiated affiliation agreements.
- Institute a public health rotation for graduate medical trainees in the County system by academic year 2002.
- Expand the community-based planning process using the findings from the L.A. Health Survey—which is conducted every two years—to address reversible risk factors for common diseases and injuries.
- Respond to strategies and recommendations developed by the Women's and Children's Health Policy Summits.

Managing Costs

- Continue implementation of cost efficiencies and service consolidations. The enterprise-wide reengineering project is still underway, with a revised target to save $82 million annually by FY 2000-01.

- Improve the cost-effectiveness of inpatient services by 5% through the implementation of clinical pathways (e.g., improve management of cellulitis, pneumonia, and congestive heart failure).

Reducing the Burden of Disease

- Complete the reorganization of public health to improve the assessment of health needs and priorities for each major planning area.

- Reduce reversible risk factors for common diseases and injuries, including tobacco, alcohol, drug abuse, sedentary life style, and violence.

Health Care Workforce Retraining

- Enhance the skills of ambulatory care workers to meet the evolving and changing demands under managed care through a collaborative labor-management process.

- Support assessment, training, placement, and other transition strategies for the 2,400 hospital-based employees at-risk due to the largest and most complex reengineering project in the nation among public health systems.

- Improve core public health competencies of 3,700 workers and prepare new employees for emerging roles in the assessment, development, and evaluation of health services.

The approval of the extension request and the proposed amendments to the Medicaid Demonstration Project for Los Angeles County will advance the restructuring of the County health system, and assist in implementing new programmatic initiatives through fiscal reform.

* * *

Under the current Demonstration Project, the County has made significant progress toward structural changes and seeks to continue that process and move toward managing disease and patient care. Restructuring that involves expanding ambulatory care, integrating public and private providers (“partners”), changing fiscal disincentives and long-standing clinical practices requires both time and the commitment of resources. To continue the restructuring process,

the County is requesting the State and Federal governments to extend the Project for another five years.

The extension of the Project will allow the County to continue working with its partners, including private health service providers, free and community clinics, health care organizations, academic institutions, labor, and consumer advocates/community representatives to realize a common vision: a vastly improved health services system for the County's vulnerable Medi-Cal and indigent populations.

I. INTRODUCTION

The sweeping and dramatic changes which are occurring in the practice, financing and delivery of health care services are contributing to a fundamental restructuring of the Los Angeles County Department of Health Services ("DHS" or "Department"), the second largest public health system in the nation. With critical assistance and support from State and Federal governments through the Medicaid Demonstration Project ("Project," "Demonstration Project," "Waiver," or "1115 Waiver"), the Department is transforming its large, decentralized, hospital-based system. The emerging system is a blended model of DHS facilities and public and private partnerships organized around managed care principles and guided by public health leadership and planning.

While DHS has made progress toward system restructuring, it has proven more complex and difficult than expected. Nevertheless, during the past three and a half years, DHS has demonstrated progress toward making a much-needed shift from inpatient and specialty care to primary and preventive care, in addition to a greater emphasis on population-based public health services. This is being done through a number of ongoing operational strategies such as inpatient reductions, system-wide reengineering, reorganization of public health, outpatient care expansion, and new medical school affiliation agreements designed to expand primary care training such as family medicine to ambulatory care settings.

This document outlines the framework for the continued restructuring of the Los Angeles County public health system under the current Medicaid Demonstration Project for Los Angeles County.[1]

In addition to this introduction, the document is organized into the following six major sections:

Section II: Issues Impacting the County Safety Net System
Section III: Progress Update
Section IV: Adequacy of Financing and Reimbursement
Section V: Project Plan for Fiscal Years 2000–2005
Section VI: Supporting Documentation
Section VII: Proposed Amendments

Sections II and IV provide the framework that underlines the County's structural paradox: (1) factors it has no control over, such as the increasing uninsured population—particularly the working uninsured; and (2) reimbursement that is tied to inpatient services, which provides limited incentives to create a balance between inpatient and outpatient services. Despite new revenues through the Demonstration Project, the increase in outpatient revenue has been insufficient

1 The Health Care Financing Administration ("HCFA") granted the Demonstration Project under the authority of section 1115 of the Social Security Act.

to offset the loss of inpatient revenue, as a result of dramatic losses and reductions in hospital-based services.

Section III describes the Department's progress over the last three and one-half years. Section V describes the Waiver objectives for Fiscal Years 2000-2005.

Section VI describes the supporting documentation under the current Terms and Conditions of the Demonstration Project. Section VII outlines the proposed amendments for FY 2000-01 through FY 2004-05.

II. ISSUES IMPACTING THE COUNTY SAFETY NET SYSTEM

Although the County Department of Health Services ("DHS") has made notable progress towards meeting program objectives under the current Demonstration Project, the restructuring goals of reducing inpatient and expanding outpatient care cannot be sustained unless the structural and financial problems which contributed to the original fiscal crisis are addressed. The underlying problems confronting the County have not been resolved. These include:

Welfare Reform and Declining Medi-Cal — After more than twenty years of steady growth, the number of Medi-Cal eligibles has declined throughout the State. For example, the number of Medi-Cal eligibles in Los Angeles County has steadily decreased from 1.9 million to about 1.7 million since 1995.[2] Between January 1996 and January 1998, the number of AFDC/TANF cases in Los Angeles County decreased by 23%.[3] Major studies demonstrate that welfare reform has been a significant factor in the decline in Medicaid enrollment.[4]

Shift of Medi-Cal Population/Reliance on Safety net —The County public hospital system has lost 132,000 Medi-Cal inpatient days, a 26.1 percent drop, since 1994-95. This has serious implications for the County's health care system, which provides over 85% of all uncompensated care in Los Angeles County.[5] Because the County relies heavily on revenue from inpatient hospital services, these reductions jeopardize the continued ability of the health care safety net to serve both Medi-Cal and indigent patients. About 7% of uninsured adults rely on County facilities as their regular source of care.[6] Additionally, although the percent of children who use County health facilities as a regular source of care has not yet been analyzed, County facilities in FY 1996-97 provided services to over 114,000 children age one through eighteen, about 15 percent of the total user population at County facilities (excluding public health and patients seen by private providers).

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2 Department of Health Services, California (1998), [Internet]. State of California. Available: http://www.dhs.cahwnet.gov/admin/ffdmb/mcss/publishedreports/annual/mcannual98/98report.htm [1999, July].

3 Zimmerman, W., & Fix, M. (1998). *Declining Immigrant Applications for Medi-Cal and Welfare Benefits in Los Angeles County*: The Urban Institute.

4 Publication, Families USA (1999). *Losing Health Insurance: The Unintended Consequences of Welfare Reform*: Families USA Foundation.

5 OSHPD (1997). *OSHPD Quarterly*: Office of Statewide Health Planning and Development.

6 LADHS (1997). *Los Angeles County Health Survey*. Los Angeles: Field Research Corporation. USC School of Public Administration and the UCLA School of Public Health collaborated on this project. Estimates are based on weighted data applied to population estimates from the 1996 Current Population Survey.

Limited Success of Expanding Insurance Coverage — Despite the recent improvements to expand insurance coverage to children at the Federal and State levels, these do not offset the annual declines in Medi-Cal coverage and the low rate of job-based insurance. The uninsured rate for children has not changed significantly; even under the "best case" scenarios there would still be more than 300,000 children uninsured.

Large and Rising Uninsured — The uninsured population has steadily increased despite a rebounding local economy. Most estimates indicate, however, that the highest job growth has been in low-wage jobs that typically do not offer health insurance coverage. Thus, the uninsured population is expected to continue to rise. Over the past two years, the County has averaged about 150 new uninsured persons per day.

Continued financial incentives for inpatient and emergency services — Despite the program changes that have reduced inpatient and inappropriate emergency services, very little net savings to the County have resulted due to losses in Federal and State revenues. The current Medi-Cal funding mechanisms create a "Catch 22" for County DHS. Progress toward the County's restructuring goals does not produce the significant financial savings necessary to maintain the changes.

Limits in Payments to Safety Net — Even with 1115 Waiver funds, the total federal funding available to County DHS has declined from $1.2 billion to $1.1 billion since the beginning of the Demonstration Project. The proportion of the DHS budget composed of federal funds has dropped from 50 percent of total funding to 47 percent. The Disproportionate Share Hospital program is scheduled to decline by 19% in FFY 2002 based on the Balanced Budget Act of 1997 (BBA). Moreover, the Federal assurance of cost-based reimbursement for Federally Qualified Health Centers, relied upon by many of the County's private partners, is being phased out and will end after FFY 2003.

Underlying Structural Paradox

The problem of the uninsured[7] combined with other similarly vexing issues such as declining employer-sponsored health insurance coverage, current national welfare policy,[8] and drops in Medicaid coverage,[9] suggests that the future

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7 Based on a study conducted by the County's Internal Services Department in 1995, a significant proportion of people without health insurance comprise a large proportion of patients seen in Los Angeles County DHS facilities.

8 Kilborn, P. T. (1999, February 26, 1999). Americans Without Health Insurance Run the Gamut. *New York Times*.

9 Kaiser (1998). *Uninsured: A Chart Book*: The Kaiser Commission on Medicaid and the Uninsured.

number of uninsured in Los Angeles County may far exceed the growth rate experienced since 1990.[10]

Furthermore, as the impact of Medicaid managed care unfolds, traditional and historical sources of care for the uninsured are likely to decline,[11,12,13,14] or stop serving them altogether.[15] Many traditional providers of care are overwhelmed by lower reimbursements, inadequate capitation payments, growing costs for uncompensated care, or increasing numbers of uninsured patients.[16]

Los Angeles is the nation's epicenter for many of these dynamics: large numbers of uninsured, extensive managed care penetration, and fierce competition for covered patients from for-profit hospitals. A 1998 study by *The Urban Institute*[17] found Los Angeles County has "one of the most vulnerable safety net systems in the nation." This determination was based on an analysis of major determinants of safety net viability that compared states and major metropolitan areas across the nation.

Furthermore, the restructuring of the DHS system is not translating into significant savings for the County to meet the rising needs of the uninsured. Although inpatient capacity has been dramatically reduced, the net savings do not exist because there are minimal County operating subsidies for inpatient care. Conversely, the expansion of outpatient services, which traditionally have low reimbursement rates, have created increases in net cost to the County. Thus, despite the new revenues through the Demonstration Project, current Federal/State financing mechanisms and funding levels are insufficient to sustain a viable and stable safety net system.

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10 Schauffler, H. H., & Brown, E. R. (1999). *The State of Health Insurance in California, 1998* (January). Los Angeles: Health Insurance Policy Program.

11 Norton, S. A., & Lipson, D. J. (1998b). *Portraits of the Safety net: The Market, Policy Environment, and Safety Net Response* (November): The Urban Institute.

12 Andrulis, D. (1997). The Public Sector in Health Care: Evolution of Dissolution? *Health Affairs, 16*(4), 30-47.

13 Fishman, E., & Bently, J. (1997). The Evolution of Support for Safety-Net Hospitals. *Health Affairs, 16*(4), 30-47.

14 Norton, S., & Lipson, D. (1998a). *Public Policy, Market Forces, and the Viability of Safety Net Providers* (Assessing New Federalism Occasional Paper 13). Washington, D.C.: The Urban Institute.

15 Kilborn, P. T. (1998, August 29). The Uninsured Find Fewer Doctors in the House. *New York Times*.

16 Cunningham, P., Grossman, J., St. Peter, R., & Lesser, C. (1999). Managed Care and Physicians Provision of Charity Care. *JAMA, 281*(12), 1087-1092.

17 Norton, S., & Lipson, D. (1998a), op. cit.

III. PROGRESS UPDATE

System changes are taking place. While system reforms may not be occurring as rapidly as originally envisioned, the numerous changes and sensible steps toward restructuring the County's delivery system form a solid foundation for the continuation of this enormous undertaking. A detailed description of the Department's progress toward meeting current Demonstration Project objectives, as delineated in the Project Management Plan is included as Appendix I.

A. Hospital Restructuring

Reductions in hospital services budgets between FY 1994-95 and FY 1997-98 have been the underlying factor for the reduction in inpatient services such as budgeted beds and specialty care services.

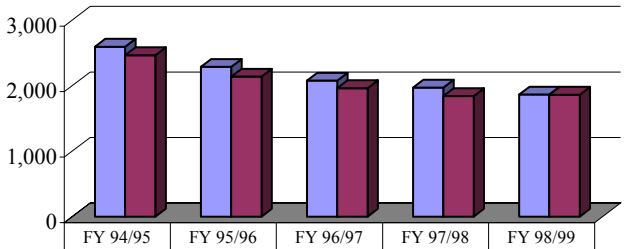
The Department has developed and implemented several restructuring activities designed to address the delivery of inpatient care; these are described below.

Reducing Inpatient Capacity

- Budgeted beds in the system have been reduced by 731 beds, declining by 28.2 percent overall since the commencement of the Demonstration Project in July 1995 (Figure 1). This decline is five times greater than the State trend and three times the national trend. Also shown in Figure 1 is the trend in the decline in County hospitals' average daily census, which is slightly over 24%.

- This reduction is almost equivalent to closing one hospital approximating the current budgeted size of the LAC+USC Medical Center—the largest public medical facility in the nation.

Figure 1: Budgeted Beds and Average Daily Census



	FY 94/95	FY 95/96	FY 96/97	FY 97/98	FY 98/99
Budgeted Beds	2,595	2,288	2,079	1,972	1,864
Avg. Daily Census	2,465	2,138	1,962	1,842	1,863

Reducing Inpatient Care

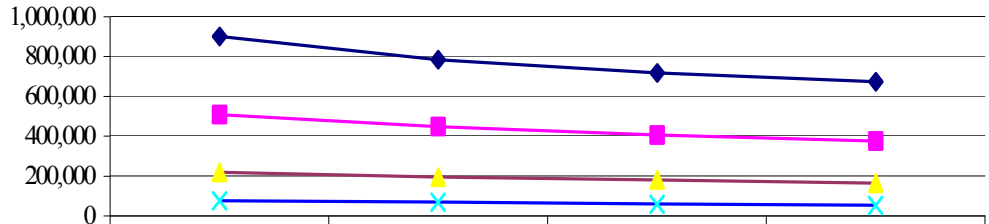
- System-wide inpatient days have declined by approximately 25.2 percent (Figure 2).

- The County's drop in average daily census is more than five times the decline in State (4.93%) and national (7.08%) trends.

- Along with the reduction in inpatient days, average length of stay ("ALOS") has also declined by half a day, from 6.4 to 5.9 for all DHS hospitals.[18] The drop in ALOS is equivalent to a reduction of over 17,000 inpatient days.

Figure 2 also shows the drop in inpatient days for the Medi-Cal, Medicare, medically indigent, and uninsured patient populations. These three groups account for close to 88% of all DHS hospitals' inpatient days.

Figure 2: Inpatient Days & Selected Payor Source



	FY 94/95	FY 95/96	FY 96/97	FY 97/98
Inpatient Days	899,354	782,337	716,034	672,330
Medi-Cal	507,042	445,948	404,938	374,923
MISP*	218,093	192,436	180,001	162,479
Medicare	74,601	68,964	58,947	53,092

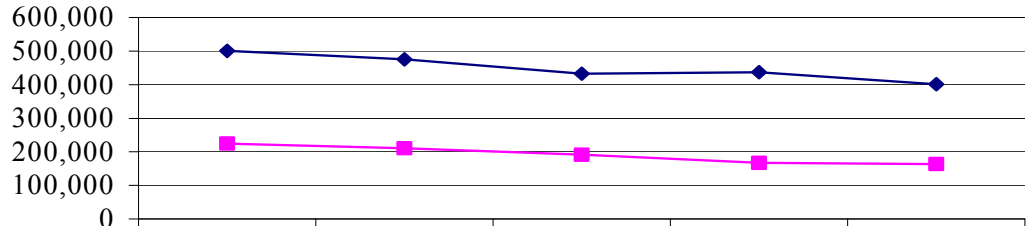
Source: MICRS . *MISP = Medically Indigent.

18 Based on State data from the Office of Statewide Health Planning and Development, County hospitals' ALOS is slightly above the overall statewide average of 5.7 days in 1996. This would be expected given that County hospitals have a higher patient acuity mix than other general acute care facilities. (State of California Web site: http://www.oshpd.cahwnet.gov/hid/support/faqs/users/faq1.htm, 1999.)

Reducing Emergency Room Utilization

As shown in Figure 3 below, utilization of emergency room services has declined by 19.8% between calendar years 1994 and 1998. The decline in non-urgent visits, 27.2% over this same period, is even more significant. The specific empirically -based causes for the decline in non-urgent visits are not known.

Figure 3: Emergency Room Utilization and Non-Urgent Visits



	1994*	1995*	1996*	1997*	1998*
Total ER Visits	500,687	475,440	432,616	436,951	401,435
Non-Urgent Visits	224,724	210,881	191,526	167,533	163,708

Source: Annual Utilization report for Office of Statewide Health Planning and Development.
* Calendar Year

By comparison, between calendar years 1994 and 1997, emergency room services increased by 15.97% State-wide and by 2.57% nationally.[19]

Empirical data to determine a cause and effect relationship between increased ambulatory care access and reduced [inappropriate] emergency room utilization is not available, and may not be possible to determine given the existing data collection limitations. Declining hospital expenditures and staffing may be factors. The Department has also taken small steps in managing emergency room utilization, e.g., LAC+USC Medical Center emergency room users requiring follow up within a couple of days are given appointments to the "1050" Walk-in Clinic to prevent an unnecessary emergency room visit for follow up care. Also, Wilmington area residents using the Emergency Department at the Harbor/UCLA Medical Center are referred and linked to Family Practice at the Wilmington Health Center. The impact of these efforts on emergency room utilization has not been quantified. However, the Department will continue to monitor emergency room utilization data to determine any discernible trends, and develop additional programs for decreasing inappropriate emergency room utilization.

19 AHA (1999). *Hospital Statistics, 1999 Edition*. Chicago: American Hospital Association.

Reconfiguring the Specialty Care System

In an effort to reconfigure the delivery of specialty care services (including outpatient surgery) to enhance patient access, selected specialty clinics have been relocated or supplemented at the comprehensive health centers and health centers. There is a clear need to add specialty care services to meet community need and demand on a timely basis, particularly since PPP providers are so dependent on County specialty services. Current integration efforts have fallen short of mitigating appointment wait times and meeting demand in part due to the specialty care services reductions in FY 1995-96. Although the County had budgeted additional funds in FY 1997-98 to increase ambulatory care services within the Department, the inability to hire appropriate staff quickly impacted visit growth.

Relocation of specialty clinics typically requires an assessment of the appropriateness of the service for migration and relocation of attending staff and residents. For example, specialty services requiring high technology equipment often must remain in the hospital setting. Nevertheless, examples of specialty clinic relocations include the following:

- Moved geriatrics, gynecology (high risk OB), neurology, and adult medicine clinics from MLK/Drew Medical Center to selected health centers.

- Restored specialty service at High Desert Hospital, including oncology and neurology clinics.

- Initiated dermatology and anti-coagulation clinics at Northeast Cluster comprehensive health centers.

- Relocated ophthalmology services from the Harbor/UCLA Medical Center to the Long Beach Comprehensive Health Center.

In some instances, clinics were also added (rather than relocated), e.g., instead of relocating high-risk OB/GYN clinics from Olive View/UCLA Medical Center, those services were made available at the North Hollywood HC and Mid-Valley CHC as well. The Olive View/UCLA Medical Center is actively assessing the relocation or addition of other specialty services (i.e., ophthalmology, ENT, cardiology, dermatology, and pulmonary) to CHCs or other HCs. Other hospital clusters are engaged in similar assessments.

Referral Centers

DHS referral centers were established to coordinate specialty and inpatient services with PPP, General Relief (GR), Community Health Plan (CHP), County operated health centers, and other providers. In general, the functions of the Referral Centers include:

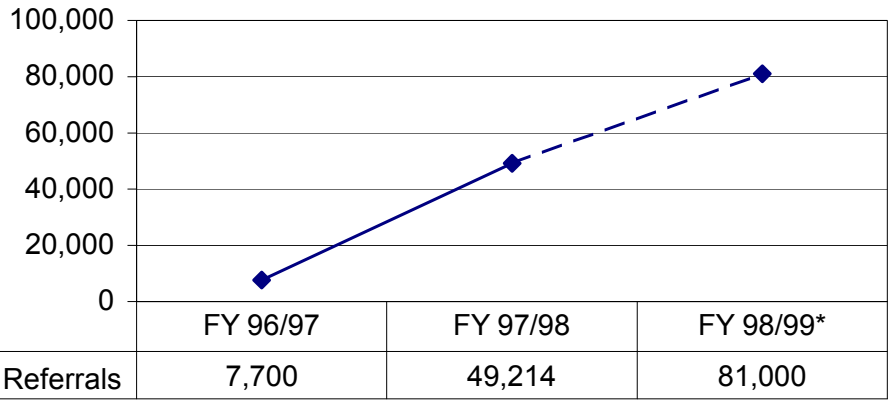
- Screening referrals for completeness (i.e., does the referral include sufficient medical information for an effective specialty consultation?) and appropriateness (i.e., is the requested specialty service appropriate for the medical condition?);

- Coordinating and facilitating communication between the referring provider and the specialty clinic; and

- Making appointments as the capacity of the specialty clinics permit.

Overall, the number of referrals for specialty care has continued to increase dramatically since the centers were established in FY 1996-97. Figure 4 illustrates the projected volume of specialty care referrals through the end of FY 1998-99. Although the use of referral centers is increasing, appointment-waiting times continue to be lengthy for specialty services in high demand.

Figure 4: Referrals Received



	FY 96/97	FY 97/98	FY 98/99*
Referrals	7,700	49,214	81,000

Source: Hospital Referral Centers (Referral Centers were implemented in FY 96/97.)
* Projected based on referrals thru 12/31/98.

Renegotiating Graduate Medical Education Affiliation Agreements

Over the past several years, Department hospitals have begun to move toward developing a balanced, integrated delivery system, including refocusing the affiliation with the three medical schools (University of Southern California School of Medicine, University of California at Los Angeles School of Medicine, and Charles R. Drew University of Medicine and Science) toward joint planning, as shown by the points below.

- The newly negotiated relationships embody a process by which to facilitate collaboration and communication between the Department and medical schools related to the elimination, consolidation, creation, or expansion of medical education training programs.

- One goal under the new medical school affiliation agreements is to expand primary care training, such as family medicine, into the ambulatory care setting. An example of these efforts is the inclusion of a new family medicine training program in the USC affiliation agreement, which is to be administered through the LAC+USC Medical Center. This program will train family medicine residents in an ambulatory clinic setting.

- A similar family medicine program is being planned at Olive View/UCLA Medical Center.

- Additionally, the County's CHCs and HCs would be integrated into the affiliation agreements to expand primary care training at these facilities.

Piloting Clinical Resource Management (CRM)

The CRM initiative consists of programs and tools to assist the Department in the development of outcomes-based measures and quality-of-care standards across the inpatient and outpatient continuum of care. The three programs currently being developed are clinical pathways, disease management, and case management.

B. Reengineering

For the first two years of the Project, inpatient reductions occurred primarily because of budget cuts. Beginning in Year 3 of the Project, the Department began a process to redesign its health care system through reengineering. Aggressive targets were established which proved to be unrealistic. Accordingly, based on an analysis by the County's Chief Administrative Office (CAO) and Auditor-Controller ("A-C"), the Department's reengineering efforts are expected to yield $82.4 million in savings per year by FY 2000-01 (Table I).

Table I. Projected Reengineering Savings

Fiscal Year	FY 97/98	FY 98/99	FY 99/00	FY 00/01
Reengineering Savings ($ millions)	$5.0	$40.7	$70.9	$82.4

The analysis concluded that while CRM, the single largest component of the reengineering savings target, has the potential to improve the delivery of health care, it will ultimately result in substantial losses in Federal and State revenue because of the decline in inpatient days. Moreover, the CAO and A-C's report concluded that until the revenue impact of CRM can be ascertained, the CRM savings are too uncertain to be included in projected savings.

Under a new policy direction, the Department established an oversight committee—comprised of management, labor, and community stakeholders—to evaluate the reengineering plans, ensure accountability in their implementation, and assure compliance with expected deliverables. This new strategy is a shift from a top-down management approach to one that integrates labor and community representatives in implementing reengineering.

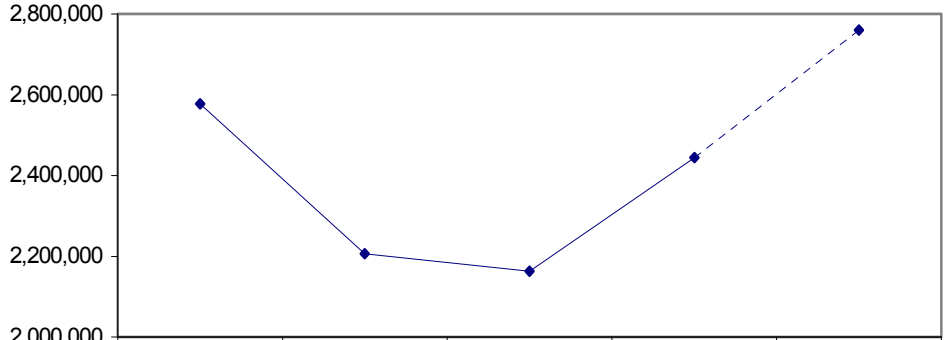
C. Outpatient Care Expansion

DHS has geographically expanded access to primary care services for the uninsured from 45 County-operated primary care access points in FY 1994-95 to 149 public/private sites in FY 1998-99.

- Increased access was achieved through a new PPP program involving free and community clinics and private community-based providers.

- The blended public/private system is expected to generate 2.76 million visits by June 30, 1999. If 2.76 million visits are achieved, it will represent a 7% increase over the FY 1994-95 level (see Figure 5 below).

Figure 5: Ambulatory Care Visits



	FY 94/95*	FY 95/96	FY 96/97	FY 97/98	FY 98/99**
◆ AmCare Visits	2,577,181	2,206,708	2,162,897	2,443,996	2,760,000

Data Source: Hospital and CHC/HC data from Workload Statistics Report, PPP data from AIA claims adjudication, as of 12/31/98.
* PPP and GR contract programs were established in FY 95/96. GR and PPP programs began 10-95.
** FY 98/99 data are based on "estimated actuals" as of Nov. 1998.

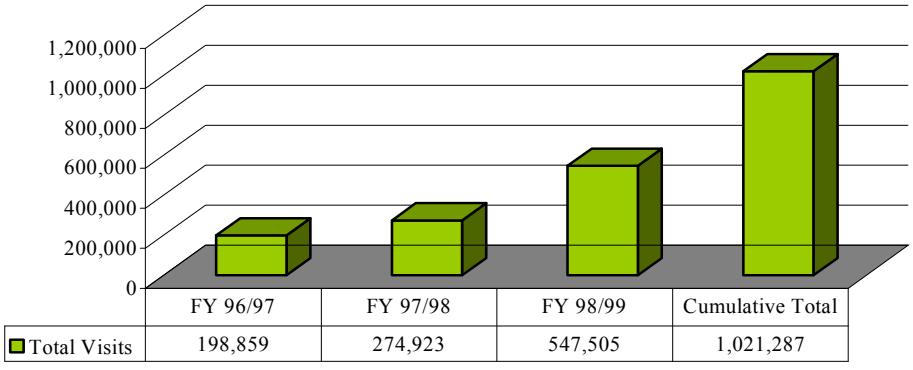
Although the number of access points have increased dramatically since the beginning of the Demonstration Project through expansion of public and private partnership sites, the overall target number of visits has not been met. In addition, specialty services continue to have long waiting times for appointments. Access is not simply a measure of visit volume, but also includes the capacity to provide community-based primary and preventive care services where patients can readily access them without delaying needed care because of financial, transportation, or cultural and linguistic barriers. The Department's ambulatory care expansion efforts have sought to ensure that its PPP primary care practitioners and facilities not only enhance access through increased visits, but also expanded hours (evenings and weekends), and enhanced services. Indicators to assess the full extent of increased access include nurse encounters, home health visits, telephone contacts, and nurse triage encounters. While these types of access indicators have not been previously reported to HCFA, they are critical components of increasing all dimensions of access for the uninsured.

The progress toward expanding geographic-based access and restoring ambulatory care services at DHS-operated facilities is described below.

Expanding Access through Public/Private Partnerships

While not all public/private partnership providers have performed as anticipated, based on their funding allocation, taken together, they have been an important source of primary care expansion at the community level. Figure 6 illustrates the PPP ambulatory care growth; the expected number of visits in FY 1998-99 is based on projected data.

Figure 6: PPP Number of Visits

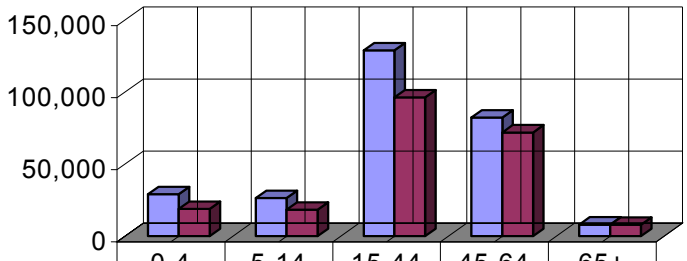


	FY 96/97	FY 97/98	FY 98/99	Cumulative Total
Total Visits	198,859	274,923	547,505	1,021,287

Source: AIA Data. PPP program was not initiated until FY 95/96. PPP data not available for FY 95/96.

As shown in Figure 7, the PPP use rate among all age groups is highest for those aged 15-64. According to the L.A. Health Survey, nearly one third of adults 18 to 65 years of age in Los Angeles County do not have health insurance, which is the population with the highest uninsured rate among all uninsured persons.

Figure 7: PPP- Number of Visits by Age Group

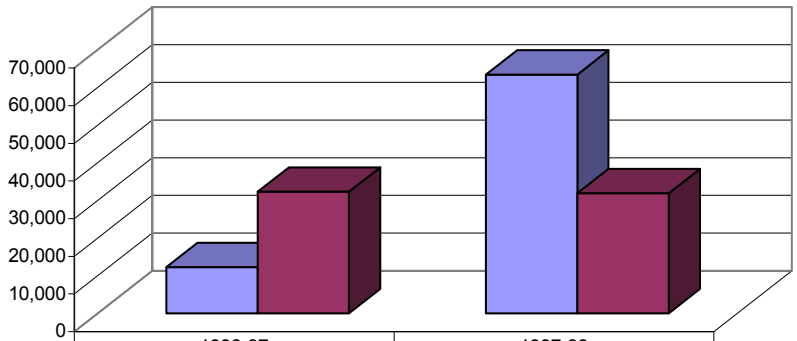


	0-4	5-14	15-44	45-64	65+
FY 1997/98	29,156	26,446	129,011	82,292	8,018
FY 1998/99 thru 12/31/98	18,928	18,293	96,330	71,960	7,906

Source: AIA

As shown in Figure 8 below, the volume of PPP patients diagnosed with ambulatory care sensitive conditions (ACS) increased fivefold between FY 1996-97 and FY 1997-98. During this same period, the number of public hospital discharges for ACS has declined slightly, suggesting a possible association between increased ACS primary care visits and ACS hospital discharges.

Figure 8: Ambulatory Care Sensitive Conditions (ACS)
PPP Visits and Hospital Discharges



	1996-97	1997-98
ACS PPP Visits	12,260	63,372
ACS Hospital Discharges	32,273	31,876

Restoration of County Ambulatory Care Services

The Department is taking a number of concrete steps to ensure a continued upward trend in visits. These include the following:

In FY 1998-99, the Department budgeted 421.3 additional full-time-equivalent positions specifically designated for ambulatory care expansion in DHS facilities. The positions were allocated by cluster as follows: Coastal (40.3 positions), Northeast (175 positions), Southwest (105 positions), and San Fernando (101 positions). After review and classification by the County's Human Resources, the hiring process began in September 1998. The table below shows the breakdown by position category within each cluster.

Position Category	Coastal Cluster	Northeast Cluster	Southwest Cluster	San Fernando Cluster	Total
Physicians	4.3	9.2	7.0	7.0	27.5
RNs	10.0	40.2	17.0	16.0	83.2
Nursing Attendants	4.0	10.0	9.0	14.0	37.0
LVNs	4.0	15.2	13.0	13.0	45.2
Clinical Support	4.5	35.5	13.0	17.0	70.0
Clerical	12.5	52.7	41.0	33.0	139.2
Other*	1.0	12.2	5.0	1.0	19.2
TOTAL	**40.3**	**175.00**	**105.0**	**101.0**	**421.30**

* Includes payroll titles such as Patient Resources Worker, Patient Financial Services Worker and Staff Assistant (I and II).

- Appointment of a Director of Ambulatory Care in October 1998 to ensure effective outpatient care expansion efforts at County Comprehensive Health Centers and Health Centers.

- Development of a better assessment methodology process of how access to ambulatory care has improved since the beginning of the Demonstration Project. The scope of this action involves capturing data that indicate access to services, but do not meet the traditional definition of a "visit" (e.g., nurse triage visits, telephone consultations, and case management activities).

- Initiated an analysis to determine the optimal reconfiguration of the County's ambulatory care system. Preliminary analysis indicates that three to four additional comprehensive health centers may be needed countywide, including at least two comprehensive health centers in the LAC+USC Medical Center service area.

- An Inspection and Audit Division Health Center Assessment was completed during the third quarter of FY 98/99 to verify ambulatory care workload data.

- The Department is in the process of completing a comprehensive facility analysis and action plan. Specific short-term and long-term

recommendations will be developed for all health centers based on the findings.

DHS Ambulatory Care Community-Based Planning

- At the Board's direction, the County implemented a community-based, ambulatory care planning process by service planning area, involving over 400 participants and utilizing data from the LA County Health Survey.

- The initial results of this process produced the County's first Ambulatory Care Plan, approved by the Board of Supervisors in February 1999. Plans are to conduct this process annually.

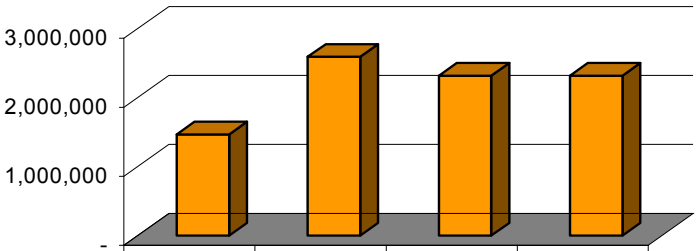
- The community-based planning process will involve assessing needs and priorities to guide resource allocation, specifically linked to community priorities and needs/demand analysis.

County Expanded Ambulatory Care Services

In addition to DHS ambulatory care expansion efforts, other County safety net services have also been expanded. The Figures below show the volume of visits for three outpatient visit categories. Figure 11 shows Alcohol/Drug Program Administration (ADPA); Figure 12 shows Mental Health (MH); and Figure 13 shows the Office of AIDS Policy and Programs (OAPP) services provided by the County. Many providers traditionally serving these populations or contracting with the County for these services are also part of the PPP program provider network.

In FY 1997-98, Alcohol and Drug Program Administration provided an estimated 2,318,403 outpatient visits (Figure 11).

Figure 11: Alcohol and Drug Program Administration

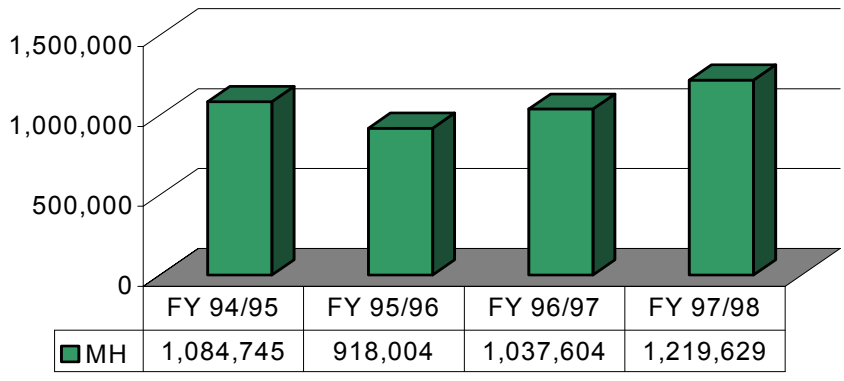


	FY 94/95	FY 95/96	FY 96/97	FY 97/98
ADPA	1,470,382	2,593,724	2,318,403	2,318,403

Source: ADPA -Finance

In FY 1997-98, the Department of Mental Health provided 1,219,629 outpatient visits (Figure 12). As collaboration continues between ADPA and DMH, the Department expects to improve coordinated care for patients with physical, mental, and/or substance abuse conditions.

Figure 12: Mental Health

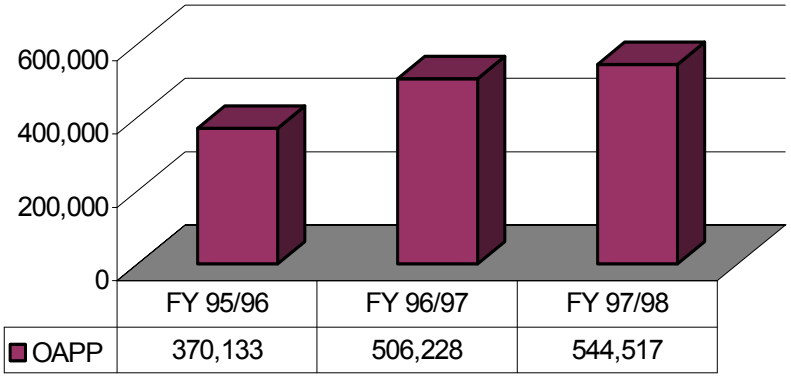


	FY 94/95	FY 95/96	FY 96/97	FY 97/98
MH	1,084,745	918,004	1,037,604	1,219,629

Source: Department of Mental Health

In FY 1997-98, the Department's Office of AIDS Programs and Policy provided 544,517 outpatient visits, including case management, day treatment, dental care, HIV testing, medical care, mental health, paraprofessional care, rehabilitation, specialized care, detoxification and substance abuse treatment (Figure 13).

Figure 13: Office of AIDS Programs and Policy



	FY 95/96	FY 96/97	FY 97/98
OAPP	370,133	506,228	544,517

Source: OAPP Reporting Systems

D. Public Health

In September 1997, the UCLA School of Public Health completed its analysis of the County's public health functions. The Department's reorganization and direction of its public health functions are based on UCLA's recommendations.

Based on the UCLA study, the Department moved quickly to develop a vision for reorganizing public health services in Los Angeles County and developed an implementation plan. The re-invigoration of the Department's public health services required significant changes to produce an organizational structure that would reflect a commitment to community-centered work, a focus on evidence-based planning and program development, and a strengthened capacity to more effectively implement the core public health functions: "assessment," "assurance," and "policy development."

Although the Department has increased funding for public health reorganization, full implementation has been delayed because of recruitment issues. For example, only three of the Area Health Officers have been hired. Described below are some of the highlights of public health restructuring efforts, including outlining areas that still need to be completed.

Reorganization of Public Health

Planning, priority-setting and resource allocation decisions are being decentralized to eight geographic planning regions. In this way, public health activities and resources allocated to a region will be linked to specific outcomes for the population of the area. A primary function of this process will be to improve the assessment of health needs and priorities for each major planning area to meet the specific public health needs of communities, including the integration of public health services with personal health services, and reducing reversible risk factors for common diseases and injuries, including tobacco, alcohol, drug abuse, sedentary life style, and violence.

The Department is still in the process of setting up eight Area Health Offices with multi-disciplinary teams sited within each of the eight service planning areas.

Planning and Evaluation

Overall, planning and evaluation are moving under the Department's public health organization to assure the application of public health principles and reduce the predominance of the personal health services delivery system in resource planning.

Health Assessment and Epidemiology

The newly established Office of Health Assessment and Epidemiology has been instrumental in assessing the health, health risks, and health problems of Los Angeles County residents. Based on L.A. Health Survey data, population-based assessments are underway. The survey will be conducted biannually.

This office will also assess disease morbidity to determine the appropriate location and placement of health services, including public health services in conjunction with the eight Area Health Offices.

Policy Development

Office of Women's Health

The Office of Women's Health was established by the Board of Supervisors on October 2, 1998 to provide a comprehensive focus on women's health issues throughout the life cycle including (1) implementation of gender-based, integrated care for women and improving women's access to routine preventive and screening exams, follow-up and treatment and (2) development of policy and program initiatives to improve women's health status in Los Angeles County.

Children's Issues

In November 1998, Proposition 10, the State and County Early Childhood Development Programs Additional Tobacco Surtax was voted on and passed. Proposition 10 increases the State surtax on cigarettes and other tobacco products and creates State and County commissions to oversee the expenditure of these revenues on early childhood development and smoking prevention programs.

Los Angeles County established its local oversight commission, the Los Angeles County Children and Families First Proposition 10 Commission, and appointed its members comprising representatives from several County departments, Board of Supervisors' offices, and ex-officio appointees.

E. Managed Care Transition

The Department has made considerable progress in developing a comprehensive provider network for the Community Health Plan ("CHP," the Department's Knox-Keene-licensed health plan) and the Healthy Families Program.

- The Department was notified in November 1998 that the State Department of Corporations (SDOC) had approved one of two material modifications submitted for Region 12 (South Bay area), a region previously excluded from

the CHP service area. This will enable the Department to increase its Medi-Cal managed care market share.

- DHS is awaiting a second material modification request, covering selected parts of the San Gabriel, San Fernando, North Hollywood, Los Angeles, West Los Angeles, and Glendale/ Pasadena areas.

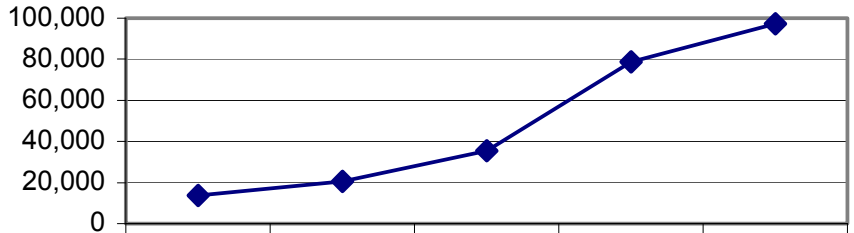
- Until the second material modification is approved by SDOC, CHP is prohibited from marketing in those areas. Upon approval, CHP will be sanctioned to market countywide. This will significantly enhance CHP's promotability to a larger market and thus improve both its capacity to retain current market share and to sustain growth.

Medi-Cal Managed Care

Since FY 1995-96, CHP has evolved from a County facility/hospital-centered health plan to an expansive health maintenance organization with over 581 primary care providers, 1,245 specialists, 1,019 pharmacies and 21 hospitals significantly improving the access available to its CHP members.

- CHP enrollment of Medi-Cal lives has exponentially increased from approximately 14,000 in FY 1994-95 to nearly 100,000 by the end of December 1998 (Figure 14).

Figure 14: CHP Enrollment



	FY 94/95	FY 95/96	FY 96/97	FY 97/98	FY 98/99*
CHP Enrollment	13,715	20,650	35,494	78,784	97,275

Source: DHS Office of Managed Care
* Enrollment through February 26, 1999.

Despite these accomplishments, CHP's enrollment has been unstable; while enrollment reached a peak of over 100,000 in September 1998, it began a gradual decline with the cessation of default enrollments and completion of Medi-Cal beneficiary conversion to managed care during the same month. Given the dynamics of Medi-Cal managed care, it is very likely that competition for members among Medi-Cal managed care plans will result in increasing pressures on the safety net.

Healthy Families Program

- Effective July 1, 1998, the Healthy Families Program (HFP) was officially implemented in Los Angeles County.

- The Department, in partnership with Universal Care, has earned State designation for two consecutive years as the preferred "Community Provider Plan" for Los Angeles County. HFP extends health care coverage, including, dental, and vision, to children ages 1 through 18 with family incomes above the no-cost Medi-Cal eligibility level and below the 200% Federal Poverty Level.

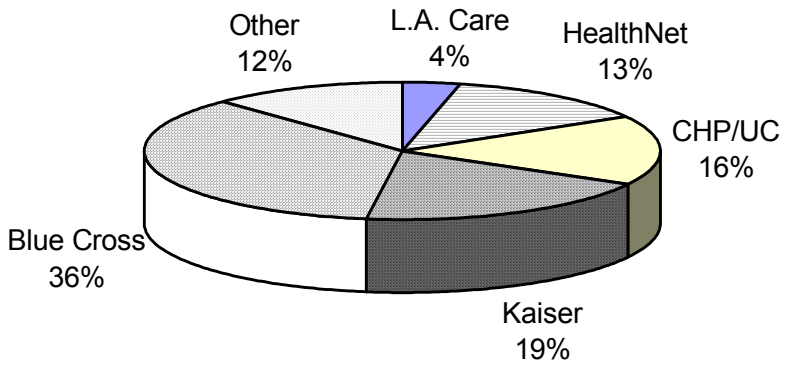
- Through its partnership with Universal Care, the County has developed an extensive provider network for the Healthy Families Program:

Primary Care Providers:	2,216
Specialists:	4,171
Pharmacies:	2,038
Hospitals:	192

Although Healthy Families enrollment continues to grow for participating plans in Los Angeles County, total enrollment falls far below the number of eligible children in Los Angeles County. As of February 1999, total enrollment in all participating plans for the HFP in Los Angeles County was 13,772, between 9.7% and 11.6% of the eligible population. The most recent estimate by the UCLA Center for Health Policy and Research of children eligible for the HFP in Los Angeles County is 118,759 to 141,379.

As of February 1999, the County's CHP, in partnership with Universal Care (CHP/UC) accounted for 16% of the total Healthy Families enrollment for the County as shown in Figure 15 below.

Figure 15: Healthy Families Enrollment



F. Services and System Integration

The Department has been engaged in a number of services and system integration efforts during this past fiscal year such as collaborating with the County Department of Mental Health (DMH) and Alcohol and Drug Program Administration (ADPA) to develop coordinated care programs. These initiatives/programs are described below.

Mental Health and ADPA

In order to improve the assessment and referral of patients for drug and alcohol problems in the primary care settings, the Department's ADPA is collaborating with DMH and the Department of Public Social Services (DPSS) to establish assessment centers in each Service Planning Area to provide substance abuse and mental health clinical assessments for CalWORKs and General Relief program participants.

- Substance abuse assessments will also be made available for the general population. On-site physical examinations will be conducted to screen for infectious diseases.

- The assessment centers will be establish and maintain linkages with other

services in order to appropriately refer patients to primary health care, HIV/AIDS services, and other DHS programs and services. Other collaborative efforts are described below.

Substance Abuse and Mental Health Program

- The Los Angeles Substance Abusing Mentally Ill (LASAMI) Project pairs ADPA-contracted alcohol and drug treatment programs with DMH clinics and contract programs to improve treatment services for persons with co-occurring mental illness and substance abuse conditions.

- ADPA and DMH also provide monthly training and peer support sessions for LASAMI peer advocate program graduates.

Sidekicks Project

- The Sidekicks Project was initiated during FY 1997-98 to improve the diagnosis and placement of dually diagnosed persons (mental illness and substance abuse) into appropriate treatment.

- Four regional centers were established through contracts with community-based agencies (*San Fernando Valley Community Mental Health Center*, *River Community Social Model Recovery Systems*, *Exodus Recovery*, and *South Central Health and Rehabilitation Program*) to develop and facilitate linkages among LASAMI programs, Drug Courts, and the Department's four acute care hospitals. The teams provide service coverage to all eight County Service Planning Areas.

Drug and Alcohol Treatment Counselors

Primary Care Settings

Paraprofessional drug and alcohol treatment counselors have been placed in primary care settings to enhance the provision of more coordinated and comprehensive care for dually diagnosed patients: (1) the conversion of ADPA contract sites from exclusive alcohol/drug treatment centers to fully comprehensive primary health care sites; (2) linkage of Community Resource Centers to primary care providers; and (3) co-location of GR Substance Abuse Assessment Centers at PPP sites (*El Proyecto Del Barrio*, *Tarzana Treatment Center*, and *AltaMed Health Services*). Under this arrangement, providers provide integrated drug/alcohol-related services and primary care services.

County Hospitals

ADPA and DMH are collaborating to implement the first phase in establishing capacity for the LAC+USC Medical Center psychiatric unit to provide diagnostic, stabilization, and treatment services for patients with co-occurring mental illness

and substance abuse conditions. The first phase adds a substance abuse counselor and resident physician to the psychiatric unit to conduct clinical diagnoses and stabilization services. These services will be coordinated with a community-based case management and day treatment program, and other treatment programs, for dually diagnosed patients.

Child/Family-Focused Collaborative

The Department has been engaged in numerous collaborative projects aimed at creating an integrated health care delivery system to provide more comprehensive care for infants, children, adolescents, and their families, listed below.

California Children's Services Medi-Cal Managed Care Pilot Project

The Department is collaborating with L.A. Care and community stakeholders on the California Children's Services' (CCS) Medi-Cal Managed Care Pilot Project, the only pilot project of this type in the State. The project is designed to study the effectiveness of administering health care services under a comprehensive managed care delivery system to children with dual Medi-Cal and CCS health care coverage.

Interagency Operation Group

The Interagency Operation Group (IOG) was created to provide a forum for County department managers, the Los Angeles Unified School District, and the Los Angeles County Office of Education (LACOE) to share information and promote interagency and community collaboration and program development on common concerns and responsibilities.

The Department has provided leadership to IOG to promote the County's vision for children and families by facilitating the generation and implementation of solutions to remove operational barriers to integrated services among County agencies and departments (e.g., sharing CalWORKS funding to jointly implement the public health nurse home visitation project under the Family Intervention and Support Program). The Family Intervention and Support Program is described below.

Family Intervention and Support Program

The Family Intervention and Support Program (FISP) is presently being developed to address issues of children living with substance abusing parents/caretakers. The program will use a home visitation model to address the needs of high-risk families impacted by alcohol or drug abuse. The Department plans to collaborate with the DPSS to serve CalWORKs clients. (Note: CalWORKs will fund FISP with Long-term Family Preservation Funds.) The

Department will initially implement FISP in at least two County Service Planning Area pilot sites before the end FY 1998-99.

MacLaren Children's Center

Department staff actively participated in a multi-agency effort to improve the operation and delivery of services at MacLaren Children's Center (MCC) to develop a community-based, intensive care system for children with complex needs.

- The Department entered into a Memorandum of Understanding (MOU) with the County Departments of Children and Family Services (DCFS), DMH, Probation, and LACOE to form the Interagency Children's Services Consortium (Consortium).

- The role of the Consortium is to coordinate the activities of the five member agencies most responsible for the County's delivery of various services to children in order to ensure effective, timely, and coordinated service delivery. A Central Administrative Unit (CAU) was established with representation from each member agency to ensure implementation of Consortium projects/system improvements.

- In anticipation of developing integrated, community-based delivery systems to meet the long-term needs of children and families, community outreach efforts were initiated, focusing on the needs of providers as partners with public agencies. Consortium agencies worked closely together to identify and clarify wraparound implementation requirements before commencing a contracting process.

G. Labor/Management Collaboration

During the first two years of DHS' restructuring efforts, most changes occurred in a crisis-driven environment, due to the severe fiscal crisis that threatened the viability of the health system. Even with Waiver funds, the Department suffered losses that resulted in the need to downsize the workforce by nearly 4,300 employees, including 2,525 layoffs.[20] The reduction of staff caused severe disruption in the delivery of health care services.

For the past year, DHS, in partnership with its employee unions, has undertaken a collaborative process to plan for workforce changes and prepare for new

20 Layoffs are for the October-November 1995 period. The workforce reduction figure is for the period October-November 1995 through July 1, 1998 (as of September 1998).

demands on service delivery systems and employees. A Labor-Management Restructuring Council, with representatives from senior management and labor unions, was formed to analyze and prepare for the changes needed, based on a long term, strategic direction and plan.

- A planning grant proposal was jointly developed to design a Workforce Training and Development Program (program) grounded on a mutual commitment of labor and management to assure delivery of quality care.
    - The planning grant will assist in creating an approach that will:
        - utilize existing public and private resources to achieve a meaningful response to Los Angeles County's health care industry changes;
        - identify and address factors which contribute to gaps in health care worker supply and demand;
        - identify knowledge and skills needed by the workforce in the new environment; and
        - develop a training and education program which will prepare the present health care workforce to deliver quality patient services and care in a changing environment while increasing their potential for job security.
- This program will rely upon the evaluation and implementation of current human resource practices, conducted as part of the DHS reengineering process, and build on the lessons learned from the Health Care Workers Retraining Demonstration, which underscored the importance of effective planning as a critical success factor in integrating training activities with work reorganization plans.
- The program follows the recommendations of the *President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry*.
- The U.S. Department of Labor awarded $1.2 million in planning funds for this endeavor to the County. An estimated three-year minimum of $60 million is necessary to implement program objectives.

H. Management Information Systems

Gradual progress is being made on the numerous management information systems (MIS) projects described in the 1115 Waiver's Project Management Plan (PMP).

- Data warehouse and itemized data collection projects (i.e., encounter data capture, DHSTI expansion, and connecting DHSTI to PPP providers) have had information systems requirements identified and these requirements have been partially implemented.

- The progress of several other projects, including adopting standards, acquiring a common user interface, and implementation of a common look-up are linked to the aforementioned projects above.

- Projects related to the acquisition and implementation of standardized Department-wide ancillary systems for laboratory, radiology, pharmacy, and a cost accounting system are in the systems requirements identification phase.

- Several other projects such as hospital information systems, interface engine technology, and data security policies are ongoing operations.

A major limitation in the scope and speed of information systems improvements are related to Y2K priorities and unresolved funding issues.

IV. ADEQUACY OF FINANCING AND REIMBURSEMENT

A. Background

For fiscal year 1995-96, the Department was forecasting a $655 million budgetary deficit. The deficit was caused by a variety of factors, whose aggregate effect had accumulated over the preceding years, ultimately resulting in the unprecedented budget deficit. Beginning with the passage of Proposition 13 in 1978, the County's ability to raise revenue has been severely limited and, combined with shifts of property tax from the County to the State to resolve State budget shortfalls, competing demands for other County services (e.g., law enforcement), and changes related to the health care industry and local demographics, DHS had exhausted available opportunities to stabilize its financial situation. By FY 1995-96, the accumulated effects of these significant factors placed DHS' safety net system in jeopardy.

More specifically, the overall decline in revenue that ultimately resulted in the FY 1995-96 deficit occurred as a result of:

- unsuccessful County efforts to secure new Medi-Cal Administrative Cost Claim funding from the Federal government;

- the cumulative effect of years of State retrenchment from helping fund local government and the Medi-Cal program;

- new federal legislation substantially reducing Medi-Cal revenue opportunities under the Disproportionate Share Hospital (DSH) program, including a drop of $184 million in SB 855 revenues from FY 1994-95 levels; and

- the expiration of federal immigration relief revenues (SLIAG).

In response to the budget crisis, the County Chief Administrative Officer recommended major reductions in services, including the closure of the LAC+USC Medical Center. Because the service reduction and closure options were unacceptable, the Board of Supervisors convened a Health Crisis Task Force, chaired by former California Assemblyman Burt Margolin, to develop alternative recommendations to close the budget gap. The Board ultimately approved the recommendations of the Health Crisis Task Force, which included cutting all six Comprehensive Health Centers, 29 out of 39 health centers, and 75 percent of hospital outpatient services. The Board also initiated the pursuit of federal assistance under an 1115 Waiver.

After intense advocacy efforts by the Board and negotiations with the Federal and State governments, in October 1995, President Clinton announced approval of a five-year Medicaid Demonstration Project, which initially provided $364 million in relief for DHS for FY 1995-96. As part of the 1115 Waiver, DHS

committed to reducing hospital inpatient care by one-third, increasing outpatient care access by 50 percent, and restructuring DHS to emphasize community-based primary and preventive care.

Notwithstanding the federal financial relief, in FY 1995-96, DHS still had to cut 187 inpatient beds and nearly half a million outpatient visits, curtail the workforce by nearly 4,300 employees, including 2,525 layoffs, and reduce central administrative costs by over half. Further Board-directed cost-cutting measures included privatizing 22 DHS health centers by June 30, 1996 and implementing another one-third reduction in the County's support for Rancho Los Amigos National Rehabilitation Center (formerly known as Rancho Los Amigos Medical Center) for FY 1996-97.

B. Initial Waiver Period - Fiscal Years 1995-96 through 1999-2000

In January 1996, at HCFA's request, a five-year financial projection was completed indicating that, based on then-existing revenue streams, including the first year of the 1115 Waiver commitment, DHS would be $1 billion short of funding its already downsized operations and its Waiver commitments through the end of the initial Waiver period (i.e., June 2000). It appears that the Department will be largely successful in reducing the $1 billion net funding shortfall through a number of measures, principally including the following:

	($ in Millions
Reduction of the State's DSH Administrative Fee (FYs 96-97, 97-98, & 98-99)	$83.0
Two-year legislative relief from OBRA '93 Cap Limit (FYs 97-98 & 98-99)	254.0
Restructuring of State DSH program (FYs 97-98, 98-99, & 99-00)	245.0
Settlement of Medicare appeal issues (FY 96-97)	51.0
Reengineering savings (FYs 97-98, 98-99, & 99-00)	116.6
Efficiency and Consolidations (FY 96-97)	58.9
Adjustments to projected expenses mainly resulting from hiring and salary freezes and revisions to revenue projections (Ongoing)	147.3
Total	$955.8

Although the Waiver is expected to provide $1.2 billion in Federal funds for the first five years of the Project, ending June 30, 2000, reliance on Federal funds is less today than it was in FY 1994-95, the year preceding the Waiver: In FY 1994-95, DHS received 50 percent of its funding from federal sources, or a total of $1,185 billion; in FY 1998-99, DHS expects to receive only 47 percent of its total funds from Federal sources, down from $1,185 billion to $1,116 billion. As

currently projected, DHS operations will not return to the FY 1994-95 level of 50 percent Federal funding until FY 1999-00.

C. Critical Need for Waiver Extension

Notwithstanding significant programmatic progress, the fiscal restructuring/ stabilization goals of the 1115 Waiver have not been fully realized. Problems of securing adequate ongoing and stable funding to secure the Department's long-term financial viability remain unresolved. Additionally, the County's 1115 Waiver goals of reducing inpatient beds and increasing outpatient services have yielded only minimal net cost savings. This is due in part to the fact that, while cuts in inpatient services moderately reduce variable costs, there are substantial reductions in inpatient revenues, which are the primary sources of funding for County outpatient services provided to indigent patients. The chart below illustrates the dilemma: in order to add 900,000 visits to realize the Waiver goal of 3.9 million visits, inpatient days would need to be reduced by approximately 297,000 days, a reduction in patient census of over 40 percent. Such a large reduction in inpatient days produces adverse fiscal consequences due to the financial incentives attached to the provision of inpatient services.

Sample Analysis of Inpatient Hospital Shift of Resources to Comprehensive Health Centers
Projected Fiscal Year 1999-00 ($ in Millions)

Inpatient Service Shift to Generate 900,000 Visits	
Inpatient Services	
Reduced Operating Cost [1]	**$187.71**
Less: Reduced Revenues [2]	**$161.30**
Net Savings	**$26.41**
Number of Patient Days Reduced	**296,753**
Application of Inpatient Savings to CHCs	
Net Savings	**$26.41**
Revenues Generated by Service Expansion	
Medi-Cal at Current Medi-Cal Mix	**$15.81**
Other Revenue at Current Payor Mix	**$6.78**
Additional Medi-Cal with Medi-Cal Mix Increased to LAC+USC Inpatient Mix	**$0.00**
1115 Indigent Cost Match for Legal Residents (80%) [3]	**$17.60**
Total Added Operating Costs	**$66.60**
Divided by CHC's Marginal Cost per Visit (not in Millions)	**$74.00**

Notes:
(1) Based on curtailable expenses per day of $633. (2) Estimated impact on revenue based on payor mix utilized for July 2, 1998 LAC+USC Replacement Project. Includes estimated OBRA '93 impact at 40% of unreimbursed cost Average curtailable revenue per day is $544. (3) Applies to 80% of unreimbursed cost for Medi-Cal and indigent patients in CHC – a 20% undocumented persons percentage is assumed.

Without remedial intervention, even with the continuation of new revenue streams under the Waiver and enhanced DSH revenues (statutorily set to expire at the end of FY 1999-2000), the Department could still be substantially short of the funds necessary to maintain current operational levels, and would be unable to fund new expansion/restructuring initiatives.

DHS continues to face other destabilizing forces, including:

- An increased reliance on the DHS safety net by the uninsured (DHS hospitals provide over 85 percent of all uncompensated care in the County), compounded by a very large and growing uninsured population (2.7 million). Los Angeles County continues to have the highest uninsured rate among all urban areas of California; 40 percent of all uninsured Californians live in Los Angeles County. The number of uninsured is expected to increase to at least 3.0 million by 2005.

- Limited expansion of insurance coverage programs. Even if eligibility under the Medi-Cal and Healthy Families programs were expanded up to 300 percent of the Federal Poverty Level, it is estimated that about 70 percent of the uninsured population would still remain uninsured because only about 30 percent would be eligible for coverage even under the expanded eligibility criteria.

- A significant decline in indigent care revenues funded by Proposition 99 of 1988 (Tobacco Tax revenues) is anticipated in FY 1999-2000. Based on the Governor's proposed budget, funding in FY 1999-2000 is estimated to be about half of the amount received for the previous year, a loss of about $32 million in funds used to support health care services, especially emergency services, to indigent patients.

- The widespread implementation of Medi-Cal managed care and aggressive and successful competition by the private sector for County Medi-Cal patients, resulting in reduced Medi-Cal funds for the County.

- Managed care cost pressures, which threaten access to care for the uninsured and shift more low-income and uninsured persons to County facilities. Studies show that physicians in private practice, who currently derive most of their revenues from managed care, provide 40 percent less charity care than they did previously.[21] Low-income uninsured individuals report lower access to care in areas with high Medicaid managed care penetration.

21 Cunningham, P., Grossman, J., St. Peter, R., & Lesser, C. (1999). Managed Care and Physicians Provision of Charity Care. *JAMA, 281*(12), 1087-1092.

- California ranks at near the bottom of the nationwide average Federal Medicaid dollars received per recipient based on FY 1996 data as reported by the U.S. Department of Health and Human Services.

These issues threaten the ongoing financial stability of DHS and need to be effectively addressed as part of the 1115 Waiver renewal. It is critical that the Waiver be extended to provide ongoing funding of existing Waiver revenue streams, and in such a manner as to adequately support fiscal restructuring and stability to the Los Angeles County health system. Given the new State administration, the County plans to work closely with the recently appointed California Health and Welfare Agency Director and his staff to fashion effective solutions that are integrated with overall State-wide health policy and direction.

V. PROJECT PLAN FOR NEXT FIVE YEARS

This is a proposed five-year project plan to continue the unfinished business of restructuring the County health care delivery system for the under-served and uninsured populations. It is intended to serve as the guiding document for planned programmatic changes to improve the management of disease and the coordination and integration of patient care through the year 2005.

The County's strategies are guided by a vision of creating a vastly improved, integrated, and balanced health care delivery system for the medically indigent and uninsured populations in Los Angeles County. With critical assistance and support from State and Federal governments through the Medicaid Demonstration Project, the Department is engaged in a process to transform its large, decentralized, hospital-based system. The emerging system is a blended model of DHS facilities and public and private partnerships, committed to managing disease and coordinating patient care, through public health and integrated health care planning.

The plan incorporates the essential program strategies included in the first five years, as well as new strategies, such as the Clinical Resource Management Initiative, Healthy Students Partnership, and the Health Care Workforce Retraining Project. This comprehensive plan outlines specific objectives that advance the current restructuring process.

A. Major Trends

As the second largest public health system in the nation, the Department will continue to be the primary safety net for meeting the health needs of an increasing population, currently estimated at 9.8 million people. Thus, the context of this plan must take into account an overview of major trends affecting the safety net. A short list of key demographic and health-related trends in several areas is briefly noted.

Demographics

- The total population of Los Angeles County is expected to increase to 10.9 million by the year 2010, and by the year 2020 it will surpass 12.2 million.

- The population beyond the year 2000 will be younger than that of the 1990s.

Uninsured Population

- The estimated 2.7 million uninsured in Los Angeles County are expected to increase to approximately 3.0 million by 2005.

- A large proportion of the uninsured will continue to have low incomes. (Currently, 60% of uninsured have incomes below 200% of the FPL.)

- A high percentage of the uninsured will continue to be working adults and their dependents.

$ A significant number of adults will continue to face barriers to care. (Currently, over one-fourth of uninsured adults (28%) have no regular health care provider.)

$ Specific populations continue to face significant barriers to care. (Currently, groups which tend not to have a regular provider include those with incomes less than 200% of FPL, Latinos, Asians, and adults living in the South and Metro Service Planning Areas.)

Fiscal Pressures

$ Declining revenues such as Proposition 99, Medi-Cal and SB 855 (Disproportionate Share Hospital (DSH)) for public providers.

    - DSH funding will decline over the next several years. The 1997 Balanced Budget Act reduces DSH financing by 19% from FY 1995 to FY 2002.

    - The 1997 Balanced Budget Act reduces Federally Qualified Health Center funding that supports uninsured care at many clinics.

    - Private hospitals are increasing care to the Medi-Cal population and decreasing care to the uninsured.

    - Fragile and unstable funding for medically indigent and other uninsured populations.

- Health care expenditures are expected to rise faster than the Gross Domestic Product (GDP) and inflation.

- Continuing pressure to contain Federal and State Medicaid expenditures.

B. Major Goals and Objectives

Although the County has made a fundamental shift in the focus of its delivery system, more work needs to be done in the next five years to advance the complex and difficult restructuring process: efforts to develop a balanced hospital and outpatient system.

GOAL I: **Maintain appropriate inpatient capacity that delivers cost-effective services to vulnerable populations.**

Objectives:

- Reduce by 10 percent preventable hospitalizations at each acute care hospital.
- Reduce inappropriate use of emergency room services by an additional 10 percent at each acute hospital.
- Reduce costs and increase efficiencies at County's six hospitals.
- Restructure graduate medical education to align training with community needs.

GOAL II: **Expand ambulatory care access to vulnerable populations through public and private partnerships.**

Objectives:

- Increase access to ambulatory care by 50 percent and deliver 900,000 additional visits through public and private partnerships.
- Expand access to timely and appropriate outpatient specialty care.

GOAL III: **Improve safety net system's capacity to manage care for the uninsured.**

Objectives:

- Improve the performance of safety net systems for Medi-Cal and uninsured populations through enhanced monitoring.
- Align Medicaid Demonstration Project with managed care, Healthy Families, and other initiatives for the uninsured.

GOAL IV: **Focus on improving the health of all Los Angeles County residents, with special attention to those who have the poorest health status and those experiencing the greatest barriers to health care.**

Objectives:

- Develop policies and program recommendations based on population's needs.

- Develop evidence-based standards and appropriate monitoring tools to assure effectiveness of health services.

- Continuously assess needs and priorities for each service planning area based on community-based planning process.

- Develop formal linkages and referral pathways for vulnerable populations.

GOAL V: **Implement the DHS Information Technology Open Architecture Strategic Plan to enhance the Medicaid Demonstration Project.**

Objectives:

- Promote systems integration enterprise-wide, including data exchange partners, through standardization, consolidation of data, and access to information.

- Empower end users to directly manage, monitor, evaluate, and report on patient care.

GOAL VI: **Develop, design, and implement workforce retraining and development projects that support reorganization strategies and objectives.**

Objective:

- Implement workforce retraining and development projects.

GOAL VII: **Design and implement a public-private long-range strategic planning process for regional responses to resource changes.**

Objectives:

- Implement a biannual public and private countywide planning process based on L.A. Health Survey findings.

- Institutionalize funding arrangements to the extent that successful program changes demonstrate efficient use of resources.

GOAL VIII: **Enhance the monitoring and evaluation of the Medicaid Demonstration Project and measure the impact of the evolving system on the health status of County residents.**

Objective:

- Improve access to care, health insurance coverage, and the perceived health status of Los Angeles County residents.

- Improve public-private quality improvement process towards a consumer-focused, continuous quality improvement process.

- Develop and implement a system-wide indicator initiative to integrate health care costs, services utilization, and health care quality data.

The following matrix details the Demonstration Project's goals with specific objectives, potential deliverables, expected outcomes for each goal, and management accountability.

COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES

MEDICAID DEMONSTRATION PROJECT

GOALS AND OBJECTIVES FOR FISCAL YEARS 2000/01 – 2004/05

Goal #	Overall Goal	Objective	Objective-Specific Activities	#	Activity-Specific Deliverables	#	Expected Outcomes (Goal-Specific)	Accountable Managers
I	Maintain appropriate inpatient capacity that delivers cost-effective services to vulnerable populations	Reduce by 10% preventable hospitalization at each acute care hospital	Implement disease management programs for pediatric asthma (Deliverables #1-6)	1	Establish baseline measurements for each acute care hospital to track: avoidable hospital admissions, improved coordination of care, revenue impact	1	Implemented selected disease management programs	Dr. Donald C. Thomas Douglas D. Bagley
			Implement disease management programs for HIV/AIDS (Deliverables #1-6)	2	Develop clinical quality indicators	2	Reduced preventable hospital admissions for conditions for which disease management programs have been implemented by 10%	Dr. Donald C. Thomas Douglas D. Bagley
			Implement disease management programs for congestive heart failure (Deliverables #1-6)	3	Establish patient tracking and indicator monitoring mechanism for each acute care hospital			Dr. Donald C. Thomas Douglas D. Bagley
			Implement disease management programs for diabetes (Deliverables #1-6)	4	Identify protocols of specified disease management programs			Dr. Donald C. Thomas Douglas D. Bagley
			Implement disease management programs for hypertension (Deliverables #1-6)	5	Assessment of the revenue impact from implementation of disease management programs			Dr. Donald C. Thomas Douglas D. Bagley
			Implement disease management programs for co-occurring mental health conditions (Deliverables #1-6)	6	Implement disease management programs, if feasible			Dr. Donald C. Thomas Douglas D. Bagley

Goal #	Overall Goal	Objective	Objective-Specific Activities	#	Activity-Specific Deliverables	#	Expected Outcomes (Goal-Specific)	Accountable Managers
			Assess the cost and revenue impact from implementation of disease management programs (Deliverables #1and 5)					Gary W. Wells
I	Maintain appropriate inpatient capacity that delivers cost-effective services to vulnerable populations	Improve the cost-effectiveness of inpatient services by 5% through implementing clinical pathways, as they are developed, for selected diseases (variable cost)	Implement clinical pathways for appendectomy (Deliverables #1-6)	1	Establish baseline measurements in current dollars for each acute care hospital	1	Implemented clinical pathways for selected diseases	Dr. Donald C. Thomas Douglas D. Bagley
			Implement clinical pathways for cellulitis (Deliverables #1-6)	2	Develop clinical quality indicators	2	Improved cost-effectiveness of inpatient services for selective inpatient services by 5% (variable cost) through implementation of clinical pathways	Dr. Donald C. Thomas Douglas D. Bagley
			Implement clinical pathways for congestive heart failure (Deliverables #1-6)	3	Establish patient tracking and indicator monitoring mechanism for each acute care hospital			Dr. Donald C. Thomas Douglas D. Bagley
			Implement clinical pathways for pneumonia (Deliverables #1-6)	4	Identify protocols of specified clinical pathways			Dr. Donald C. Thomas Douglas D. Bagley
			Implement clinical pathways for OB-postpartum (Deliverables #1-6)	5	Identify the revenue impact from implementation of clinical pathways			Dr. Donald C. Thomas Douglas D. Bagley
			Implement clinical pathways for OB-active labor (Deliverables #1-6)	6	Implement clinical pathways, if feasible			Dr. Donald C. Thomas Douglas D. Bagley
			Implement clinical pathways for post-operative uncomplicated C-sections (Deliverables #1-6)					Dr. Donald C. Thomas Douglas D. Bagley

Goal #	Overall Goal	Objective	Objective-Specific Activities	#	Activity-Specific Deliverables	#	Expected Outcomes (Goal-Specific)	Accountable Managers
			Identify the cost and revenue impact from implementation of clinical pathways (Deliverables #1 and 5)					Gary W. Wells
I	Maintain appropriate inpatient capacity that delivers cost-effective services to vulnerable populations	Reduce inappropriate emergency room use at each acute care hospital by an additional 10%	Identify, case manage, and monitor access to services for frequent users of emergency room services (Deliverables #1-7)	1	Establish baseline measurements for each acute care hospital	1	Developed/enhanced ER utilization control programs	Dr. Donald C. Thomas Douglas D. Bagley
			Expand availability of urgent care and mental health crisis services at ambulatory care sites (Deliverables #1 and 8)	2	Develop clinical quality indicators	2	Reduced inappropriate emergency room use by an additional 10%	Dr. Donald C. Thomas Douglas D. Bagley
				3	Identify frequent users of ER services	3	Increased number of ambulatory care sites with urgent care and mental health crisis services	
				4	Identify existing ER utilization control programs and assess their impact in mitigating inappropriate ER use			
				5	Develop a case management program for frequent users of ER services and a non-hospital based medical home for such users			
				6	Establish patient tracking and indicator monitoring mechanism for each acute care hospital			
				7	Identify the revenue impact and implementation or enhancement of ER utilization control programs, if feasible			

Goal #	Overall Goal	Objective	Objective-Specific Activities	#	Activity-Specific Deliverables	#	Expected Outcomes (Goal-Specific)	Accountable Managers
				8	Expand availability of urgent care and mental health care service at ambulatory care sites			
I	Maintain appropriate inpatient capacity that delivers cost-effective services to vulnerable populations	Reduce cost and increase efficiencies and quality at County's six general acute care hospitals	Continue implementation of reengineering at acute care hospitals (Deliverables #1 and 2)	1	Institutionalize Re-engineering	1	Achieve $82 million in reengineering savings (ends in FY 2000/01)	Armando Lopez, Jr. Douglas D. Bagley
				2	Identify targeted savings for FY 2000/01 through FY 2004/05	2	Achieve targeted savings for FY 2001/02 through FY2004/05	
I	Maintain appropriate inpatient capacity that delivers cost-effective services to vulnerable populations	Restructure graduate medical education to align training with community needs	Convene joint planning and operations committees to coordinate training with medical schools to align training with community needs (Deliverables #1-5)	1	Establish baseline measurements	1	Improved coordination of planning with medical schools	Dr. Donald C. Thomas Douglas D. Bagley
			Institute public health content for graduate medical trainees in the County system by FY 2002/03 (Deliverable #3)	2	Convene joint planning and operations committees	2	Expanded model training programs including increasing: the number of graduate medical trainees rotating to non-hospital sites, instituting a public health rotation for graduate medical trainees in the County system by FY 2002/03, and expanding family medicine training programs at non-hospital sites, as appropriate	Dr. Donald C. Thomas Douglas D. Bagley
			Increase the number of graduate medical trainees rotating to non-hospital sites (Deliverable #4)	3	Institute public health content for graduate medical trainees in the County system by FY 2002/03	3	Developed innovative and strategic "at risk" models for physicians	Dr. Donald C. Thomas Douglas D. Bagley

Goal #	Overall Goal	Objective	Objective-Specific Activities	#	Activity-Specific Deliverables	#	Expected Outcomes (Goal-Specific)	Accountable Managers
			Increase number of model training programs including family medicine at non-hospital sites (Deliverable #5)	4	Increase the number of graduate medical trainees rotating to non-hospital sites			Dr. Donald C. Thomas Douglas D. Bagley
				5	Increase number of model training programs including family medicine at non-hospital sites			Dr. Donald C. Thomas Douglas D. Bagley
				6	Develop innovative and strategic "at risk" models for physicians			
II	Expand ambulatory care access to vulnerable populations through public and private partnerships	Increase access to ambulatory care delivering 900,000 additional visits through public and private partnerships	Increase availability and appropriate utilization of ambulatory care and mental health services through public and private partnerships, and pilot projects (Deliverables #1-5)	1	Establish baseline measurements for ambulatory care, home health visits, nurse only visits, referrals, telephone encounters (including pharmacy), and uninsured indigents reporting access to a "regular source of care"	1	Provided 3.9 million ambulatory care visits by FY 2004/05 (increased ambulatory care access by 50% from the base year)	Maria Elena Sanchez Douglas D. Bagley
			Enhance the integration, quality and mix of ambulatory care services through cost-effective methods that serve uninsured patients by expanding home health visits by 50% (Deliverables #1 and 6)	2	Assess the need for additional ambulatory care and mental health services by Service Planning Area	2	Expanded home health visits by 50%	Maria Elena Sanchez Douglas D. Bagley
			Enhance the integration, quality and mix of ambulatory care services through cost-effective methods that serve uninsured patients by increasing nurse-only visits by 50% (Deliverables #1 and 6)	3	Complete an annual ambulatory care plan	3	Increased nurse-only visits by 50%	Maria Elena Sanchez

Goal #	Overall Goal	Objective	Objective-Specific Activities	#	Activity-Specific Deliverables	#	Expected Outcomes (Goal-Specific)	Accountable Managers
			Enhance the integration, quality and mix of ambulatory care services through cost-effective methods that serve uninsured patients by increasing referrals by 50% (Deliverables #1 and 6)	4	Define and develop performance indicators and set standards for ambulatory care for all providers delivering care to all patient groups (e.g., GR and PPP)	4	Increased referrals by 50%	Maria Elena Sanchez Douglas D. Bagley
			Enhance the integration, quality and mix of ambulatory care services through cost-effective methods that serve uninsured patients by increasing telephone encounters (including pharmacy) by 50% (Deliverables #1 and 6)	5	Increase availability of ambulatory care and mental health services through public and private partnerships, and pilot projects.	5	Increased telephone encounters (including pharmacy) by 50%	Maria Elena Sanchez Douglas D. Bagley
			Design a uniform and standardized eligibility process for medically indigent persons up to 200% of the federal poverty level (Deliverable #7)	6	Enhance the integration, quality and mix of ambulatory care services through cost-effective methods that serve uninsured patients (e.g., expand home health services by 50%, increase nurse-only visits by 50%, increase referrals by 50%, and increase telephone encounters (including pharmacy) by 50%)	6	Increased the percentage of uninsured indigents reporting access to a "regular source of care" through patient assessment services	Gary W. Wells
			Implement strategies to align financial screening, eligibility, and enrollment at non-hospital sites (Deliverable #8)	7	Establish work group with Federal/State/County/Stakeholders to design a uniform and standardized eligibility process for medically indigent persons up to 200% of the federal poverty level	7	A standardized eligibility process for medically indigent persons up to 200% of the federal poverty level is completed	Gary W. Wells

Goal #	Overall Goal	Objective	Objective-Specific Activities	#	Activity-Specific Deliverables	#	Expected Outcomes (Goal-Specific)	Accountable Managers
			Improve the information and communication to consumers and stakeholders on ambulatory care and access County ambulatory care and other needed services (Deliverable #9)	8	Implement strategies to align financial screening, eligibility, and enrollment at non-hospital sites	8	Implemented strategies to align financial screening, eligibility, and enrollment at non-hospital sites	Maria Elena Sanchez Gary W. Wells
				9	Create a community assistance program (Ambulatory Care Advisory Council) under the office of Ambulatory Care to inform consumers and stakeholders on how to access County ambulatory care and other needed services	9	Improved communication on access to ambulatory care and other needed services including information on available coverage programs	Maria Elena Sanchez
II	Expand ambulatory care access to vulnerable populations through public/private partnerships	Provide 500,000 ambulatory care/preventive care encounters to target population by FY 2004 - 2005	Improve the health status of indigent school-age children and youth through partnerships with participating school districts (Deliverables #1and 2)	1	Develop implementation plan for school-based and school-linked services	1	Provided 500,000 cumulative ambulatory care/preventive care encounters to target population by FY 2004-2005	Fred Leaf Margaret Lee Maria Elena Sanchez
				2	Obtain State and HCFA approval of Healthy Students Partnership Initiative			
II	Expand ambulatory care access to vulnerable populations through public/private partnerships	Provision of an additional 250,000 hospital-based outpatient specialty care visits above the June 30, 2000 baseline level by June 30, 2005, and reduce the waiting time to less than 21 days for 80 percent of specialty care clinics (reduce waiting times for specialty care services that are in high demand to less than 21 days.)	Expand access to timely and appropriate outpatient specialty care in CHCs (Deliverables #1-6)	1	Establish baseline	1	Provided an additional 250,000 outpatient specialty care visits above the June 30, 2000 baseline level by June 30, 2005	Dr. Donald C. Thomas Douglas D. Bagley Maria Elena Sanchez

Goal #	Overall Goal	Objective	Objective-Specific Activities	#	Activity-Specific Deliverables	#	Expected Outcomes (Goal-Specific)	Accountable Managers
			Expand access to timely and appropriate outpatient specialty care in hospitals (Deliverables #1-6)	2	Assess need and capacity for specialty care services	2	Reduced the waiting time to less than 21 days for 80 percent of specialty care clinics	Dr. Donald C. Thomas Douglas D. Bagley Maria Elena Sanchez
			Expand access to timely and appropriate outpatient specialty care in PPPs (Deliverables #1-6)	3	Expand availability of outpatient specialty care (e.g., in CHCs, PPPs, and hospitals), as appropriate			Dr. Donald C. Thomas Douglas D. Bagley Maria Elena Sanchez
				4	Enhance referral centers to facilitate the coordination and provision of continuous, integrated and timely care			
				5	Implement appropriate utilization management protocols for specialty care referrals			
				6	Explore options that will increase availability of on-call/on-line specialists to primary care physicians for consultations			
III	Improve safety net system's capacity to manage care for the uninsured	Improve the performance of safety net systems for Medi-Cal and uninsured populations through enhanced monitoring	Improve the performance of safety net systems through enhanced monitoring (Deliverable #1)	1	Monitor each provider site at least annually for administrative, service, and quality standards and for implementation of case management protocols for ambulatory care sensitive conditions	1	Improved provider performance through annual monitoring activities	Dr. Donald C. Thomas Donald Oxley
			Implement disease management programs for ambulatory care sensitive conditions, as appropriate (Deliverable #2)	2	Implement disease management programs for ambulatory care sensitive conditions, as appropriate	2	Implemented disease management programs and case management protocols for ambulatory care sensitive conditions, as appropriate	Dr. Donald C. Thomas Donald Oxley

Goal #	Overall Goal	Objective	Objective-Specific Activities	#	Activity-Specific Deliverables	#	Expected Outcomes (Goal-Specific)	Accountable Managers
III	Improve safety net system's capacity to manage care for the uninsured	Align Medicaid Demonstration Project with managed care, Healthy Families, and other initiatives for the uninsured	Reassess Community Health Plan (CHP) strategies, options, and long-term viability (Deliverable #1)	1	Complete viability study and develop strategic plan for CHP	1	Completed viability study and developed strategic plan for CHP	Dr. Donald C. Thomas Donald Oxley Fred Leaf
			Explore options and develop strategies, to extend coverage to target uninsured populations, such as home health care workers, day care workers, and other groups (Deliverables #2 and 3)	2	Define options, strategies, and program recommendations to maximize coverage	2	Submitted recommended strategies, policies and programs to the Board of Supervisors	Dr. Donald C. Thomas Donald Oxley Fred Leaf
			Implement processes for interagency collaboration and integration of services for the uninsured (Deliverable #4)	3	Submit recommendations on proposed strategies, policies and programs to the Board of Supervisors	3	Developed/enhanced pilot projects to align and coordinate with DPSS efforts to enroll eligible populations in available programs	Dr. Donald C. Thomas Donald Oxley Fred Leaf
				4	Develop/enhance pilot projects to align and coordinate with DPSS efforts to enroll eligible populations in available programs			
IV	Focus on improving the health of all Los Angeles County residents, with special attention to those who have the poorest health status and those experiencing the greatest barriers to health care	Develop needs-based policies and program recommendations for children ages 0-5	Develop needs-based policies and program recommendations for children ages 0-5 (Deliverables #1-5)	1	Define target population and assess their health care needs	1	Developed and implemented coordinated programs to increase prevention and health promotion for target population, including strategies and recommendations developed by the Children's Health Policy Summit, as appropriate	Dr. Jonathan E. Fielding
				2	Establish an objective, evidence-based review of services for children 0-5 to improve access to services	2	Implemented/enhanced programs designed to improve the health of the target population	

Goal #	Overall Goal	Objective	Objective-Specific Activities	#	Activity-Specific Deliverables	#	Expected Outcomes (Goal-Specific)	Accountable Managers
				3	Establish patient tracking and monitoring for the target population			
				4	Develop and implement coordinated programs to increase prevention and health promotion for target population			
				5	Implement strategies and recommendations developed by the Children's Health Policy Summit, as appropriate			
IV	Focus on improving the health of all Los Angeles County residents, with special attention to those who have the poorest health status and those experiencing the greatest barriers to health care	Develop needs-based policies and program recommendations for women	Develop needs-based policies and program recommendations for women (Deliverables #1-6)	1	Define target population and assess their health care needs	1	Implemented standards to improve the quality of appropriate care and access for the target population	Kathleen Torres
				2	Establish an objective, evidence-based review of existing and preventive services for women to improve access to treatment services (e.g., cervical cancer and breast cancer)	2	Implemented/enhanced programs designed to improve the health of the target population	
				3	Establish patient tracking and monitoring for the target population	3	Decreased incidence of cervical and breast cancer for the target population	

Goal #	Overall Goal	Objective	Objective-Specific Activities	#	Activity-Specific Deliverables	#	Expected Outcomes (Goal-Specific)	Accountable Managers
				4	The Office of Women's Health and the Office of Binational/Border Health will convene a working group to develop cultural and linguistic competency standards	4	Development of guidelines and procedures to ensure that data collection is appropriate	
				5	The Office of Women's Health will convene a Latina Research Advisory Group	5	Development and implementation of outreach strategies targeting Latinas to be their own advocates for their unique health needs.	
				6	DHS will explore using the "Latina Promotoras" model for community education and outreach			
IV	Focus on improving the health of all Los Angeles County residents, with special attention to those who have the poorest health status and those experiencing the greatest barriers to health care.	Develop needs-based policies and program recommendations for high risk families	Develop needs-based policies and program recommendations for high risk families (Deliverables #1-4)	1	Define target population and assess their health care needs	1	Implemented/enhanced risk reduction programs for target population (e.g., increase in physical activity levels and consumption of fruits and vegetables; decrease in cardiovascular disease and smoking)	Dr. Jonathan E. Fielding
				2	Establish an objective, evidence-based review of services for high risk families to improve access to services	2	Implemented/enhanced programs designed to improve the health of the target population	
				3	Establish patient tracking and monitoring for the target population	3	Increased violence prevention efforts for target population	

Goal #	Overall Goal	Objective	Objective-Specific Activities	#	Activity-Specific Deliverables	#	Expected Outcomes (Goal-Specific)	Accountable Managers
				4	Develop and implement coordinated programs to increase prevention and health promotion for target population			
IV	Focus on improving the health of all Los Angeles County residents, with special attention to those who have the poorest health status and those experiencing the greatest barriers to health care	Develop evidence-based standards and appropriate monitoring tools to assure effectiveness of health services	Develop evidence-based standards and appropriate monitoring tools to assure effectiveness of health services (Deliverables #1-3)	1	Develop and implement performance budgeting for public health services to ensure that resources are being utilized to address identified community needs within each SPA	1	Improved integration and quality of public health services delivery system focusing on the residents with the poorest health status	Dr. Jonathan E. Fielding
				2	Develop quality assurance and evaluation for Public Health Programs & Services			
				3	Invest in planning and evaluation functions to ensure integrated network of public health care services that meet the needs of communities			
IV	Focus on improving the health of all Los Angeles County residents, with special attention to those who have the poorest health status and those experiencing the greatest barriers to health care	Improve the assessment of health needs and priorities for each service planning area (Deliverable #1)	Improve the assessment of health needs and priorities for each service planning area	1	Assess needs and priorities for each Service Planning Area through the community-based planning process	1	Improved availability of health access related information and participation of community stakeholders in the development of plans addressing the health needs and priorities of each Service Planning Area	Dr. Jonathan E. Fielding Ingrid Lamirault

Goal #	Overall Goal	Objective	Objective-Specific Activities	#	Activity-Specific Deliverables	#	Expected Outcomes (Goal-Specific)	Accountable Managers
			Reduce cultural and linguistic barriers for vulnerable populations accessing the DHS network (Deliverables #2 and 3)	2	Convene a working group to develop cultural and linguistic competency standards for the DHS network	2	Improved availability of information to stakeholders on health care promotion and disease prevention issues and services availability	Dr. Jonathan E. Fielding Ingrid Lamirault
				3	Expand/enhance cultural and linguistic appropriateness programs in each service planning area	3	Developed cultural and linguistic competency standards for the DHS network	
						4	Expanded/enhanced cultural and linguistic appropriateness programs in each Service Planning Area	
IV	Focus on improving the health of all Los Angeles County residents, with special attention to those who have the poorest health status and those experiencing the greatest barriers to health care	Integration of Mental Health, Alcohol/Drug Program Administration, and the Office of AIDS Programs & Policy services with ambulatory care services	Develop and implement a plan for integration of treatments for co-occurring health/mental health conditions (e.g., major depression, schizophrenia), HIV/AIDS, and/or alcohol/drug abuse (Deliverables #1-3)	1	Improve the assessment and referral of targeted patients in primary care settings (i.e., patients with co-occurring health/mental health conditions)	1	Integration of treatment of co-occurring mental health, HIV/AIDS, alcohol/drug abuse conditions with ambulatory care services	Dr. Jonathan E. Fielding Maria Elena Sanchez
				2	Increase placement of paraprofessional drug and alcohol treatment counselors in primary care settings	2	Improved access to primary care for targeted patients enrolled in drug and alcohol treatment services	
				3	Improve access to primary care for targeted patients enrolled in drug and alcohol treatment services			

Goal #	Overall Goal	Objective	Objective-Specific Activities	#	Activity-Specific Deliverables	#	Expected Outcomes (Goal-Specific)	Accountable Managers
V	Implement the DHS Information Technology Open Architecture Strategic Plan for 2000-2005 to enhance the Medicaid Demonstration Project	Promote systems integration enterprise wide, including data exchange partners, through standardization, automation, consolidation of data, and access to information	Implement an Enterprise Index (EI) that issues unique patient numbers (Deliverable #1)	1	Implement an Enterprise Index (EI) that issues unique patient numbers	1	Implemented Enterprise Index	Dr. Donald C. Thomas Zina Glodney
			Implement Ancillary Information systems for laboratories, radiology, and pharmacies (Deliverable #2)	2	Implement Ancillary Information systems for laboratories, radiology, and pharmacies	2	Implemented Ancillary Information systems	Dr. Donald C. Thomas Zina Glodney
V	Implement the DHS Information Technology Open Architecture Strategic Plan for 2000-2005 to enhance the Medicaid Demonstration Project	Develop a central data warehouse linked to local data repositories to centralize collection of essential health care data and provide access to users across the delivery system	Develop a central data warehouse linked to local data repositories to centralize collection of essential health care data and provide access to users across the delivery system (Deliverables #1and 2)	1	Collect and consolidate patient care and cost data from provider networks	1	Improved access to information system-wide	Dr. Donald C. Thomas Zina Glodney
				2	Full implementation of the WAN	2	Improved efficiency, accuracy and timeliness of data collection and reporting	
V	Implement the DHS Information Technology Open Architecture Strategic Plan for 2000-2005 to enhance the Medicaid Demonstration Project	Develop and maintain a DHS web site and facilitate expansion of web-enabled applications	Develop and maintain a DHS web site and facilitate expansion of web-enabled applications (Deliverable #1)	1	Develop and maintain a DHS web site and facilitate expansion of web-enabled applications	1	Improved access to information through the DHS Web site	Dr. Donald C. Thomas Zina Glodney
V	Implement the DHS Information Technology Open Architecture Strategic Plan for 2000-2005 to enhance the Medicaid Demonstration Project	Improve Public Health Programs and Services (PHP&S) information technology	Improve PHP&S information technology (Deliverable #1)	1	Improve PHP&S information technology	1	Improved capture and reporting of public health population-based information	Dr. Donald C. Thomas Zina Glodney John Schunhoff

Goal #	Overall Goal	Objective	Objective-Specific Activities	#	Activity-Specific Deliverables	#	Expected Outcomes (Goal-Specific)	Accountable Managers
						2	Improved integration of public health-related patient information and access to such information throughout the DHS network	
						3	Improved quality of reporting and identification of health indicators to provide consistence and effectiveness of treatment for selected diseases throughout the network	
V	Implement the DHS Information Technology Open Architecture Strategic Plan for 2000-2005 to enhance the Medicaid Demonstration Project	Improve collection of encounter data, e.g., by implementing bar coded forms, itemized data collection, and scanning	Improve collection of encounter data, e.g., by implementing bar coded forms, itemized data collection, and scanning (Deliverable #1)	1	Improve submission of encounter data from PPPs	1	Improved collection of encounter data	Dr. Donald C. Thomas Zina Glodney
						2	Improved submission of encounter data from PPPs	
V	Implement the DHS Information Technology Open Architecture Strategic Plan for 2000-2005 to enhance the Medicaid Demonstration Project	Implement Cost Accounting Systems utilizing itemized detail data to calculate true cost of providing services	Implement Cost Accounting Systems utilizing itemized detail data to calculate true cost of providing services (Deliverable #1)	1	Implement a Cost Accounting System	1	Implemented a Cost Accounting System providing ability to effectively manage, plan and control costs	Dr. Donald C. Thomas Zina Glodney

Goal #	Overall Goal	Objective	Objective-Specific Activities	#	Activity-Specific Deliverables	#	Expected Outcomes (Goal-Specific)	Accountable Managers
V	Implement the DHS Information Technology Open Architecture Strategic Plan for 2000-2005 to enhance the Medicaid Demonstration Project	Implement Managed Care Administration (MCA) system to manage provider network through application of prior authorization, case management, referral control, capitation and risk pool management, and utilization review and quality assurance processes	Implement Managed Care Administration (MCA) system to manage provider network through application of prior authorization, case management, referral control, capitation and risk pool management, and utilization review and quality assurance processes (Deliverables #1 and 2)	1	Implement Managed Care Administration (MCA) system	1	Ability to manage provider networks through implementation of Managed Care Administration (MCA) System	Dr. Donald C. Thomas Zina Glodney Donald Oxley
				2	Identify areas of efficiency, areas needing improvement, and areas with excess capacity	2	Identified areas of efficiency, areas needing improvement, and areas with excess capacity	
VI	Develop, design and implement workforce retraining and development projects that support reorganization strategies and objectives	Retrain workforce and improve service delivery	Develop programs to support staff training and development (Deliverable #1)	1	Develop programs to support staff training and development	1	Enhanced the skills and competencies of DHS employees	Fred Leaf Rene Santiago
			Implement labor management healthcare worker retraining demonstration project (Deliverables #2 and 3)	2	Implement the labor-management health care worker re-training demonstration project			Fred Leaf Rene Santiago
				3	Monitor and evaluate the progress and impact of employee training on employees and the delivery of service			
VII	Design and implement a public-private long range strategic planning process for regional responses to resource changes	Implement a biannual public and private countywide planning process based on L.A. Health Survey findings	Establish a biannual countywide planning process, with broad public and private participation based on the L.A. Health Survey findings (Deliverables #1-3)	1	Establish Health Care Planning Council	1	Policies and programs are recommended by the Health Care Planning Council to address reversible risk factors for common diseases and injuries	Dr. Jonathan E. Fielding Ingrid Lamirault

Goal #	Overall Goal	Objective	Objective-Specific Activities	#	Activity-Specific Deliverables	#	Expected Outcomes (Goal-Specific)	Accountable Managers
				2	Council to identify changes impacting health care delivery and the proposed responses by the public and private sectors			
				3	Council to recommend policies and programs to address reversible risk factors for common diseases and injuries			
VII	Design and implement a public-private long range strategic planning process for regional responses to resource changes	Institutionalize funding arrangements based on successful programs that demonstrate efficient use of resources	Institutionalize funding arrangements based on successful programs that demonstrate efficient use of resources (Deliverables #1)	1	Recommend legislative strategies and proposals to the Board of Supervisors that support institutionalizing funding, including reform options, based on successful programs that demonstrate efficient use of resources	1	Recommended legislative strategies to support/enhance program successes provided to the Board	Director of DHS CAO County Legislative Strategist Gary W. Wells
VIII	Enhance the monitoring and evaluation of the Medicaid Demonstration Project and measure the impact of the evolving system on the health status of County residents	Measure health care access, health insurance coverage, and perceived health status of Los Angeles County residents	Measure health care access, health insurance coverage, and perceived health status of Los Angeles County residents (Deliverable #1)	1	Conduct a countywide biannual population-based survey (L.A. Health Survey), to measure health care access, health insurance coverage, and perceived health status, risk factors, and barriers to care for Los Angeles County residents	1	Report data on population-based measures	Dr. Jonathan E. Fielding

Goal #	Overall Goal	Objective	Objective-Specific Activities	#	Activity-Specific Deliverables	#	Expected Outcomes (Goal-Specific)	Accountable Managers
VIII	Enhance the monitoring and evaluation of the Medicaid Demonstration Project and measure the impact of the evolving system on the health status of County residents	Establish a public-private quality improvement process to increase patient satisfaction and perceived quality of care	Establish a public-private quality improvement process to increase patient satisfaction and perceived quality of care (Deliverables #1-5)	1	Measure patient satisfaction with PPP and DHS services, quality of care, etc.	1	Development of polices designed to increase the level of patient satisfaction and appropriate access to care	Dr. Donald C. Thomas Rene Santiago
				2	Establish independent monitoring/ombudsman function	2	Development of standard quality assurance and improvement system	
				3	Develop consumer-driven quality improvement process to assess the effectiveness of a "restructured system"			
				4	Establish link to complaint line and a proactive approach to system changes to address problems/barriers experienced by individual patients			
				5	Determine system improvements, where appropriate, for a uniform standard of care			
VIII	Enhance the monitoring and evaluation of the Medicaid Demonstration Project and measure the impact of the evolving system on the health status of County residents.	Develop and implement a system-wide indicator initiative to integrate health care costs, services utilization, and health care quality data	Establish a standardized cost, utilization and quality data collection and reporting system (Deliverable #1)	1	Establish a standardized cost, utilization and quality data collection and reporting system	1	Improved system-wide cost, utilization, and quality data reporting to monitor and evaluate the 1115 Waiver	Dr. Donald C. Thomas Gary W. Wells Fred Leaf Rene Santiago

VI. SUPPORTING DOCUMENTATION

A. FY 1995-96 to FY 1999-00 Objectives

Section III describes the County's (Department of Health Services) overall progress under the Demonstration Project by general program areas, while Appendix I (Progress Matrix) describes specific accomplishments and actions taken by the Department to meet the goals and objectives delineated in the Project Management Plan.

B. Special Terms and Conditions

While Section III highlights programmatic achievements, this section describes the County's administrative compliance with the Special Terms and Conditions (Terms and Conditions) governing the Project. In addition to restructuring goals, the Terms and Conditions describe an operational plan, requirements for federal financial participation (FFP), administrative and reporting requirements, and specific milestones. Although the intent of this section is to discuss compliance with all of the Terms and Conditions, its focus is primarily on the administrative and reporting requirements and specified milestones. The terminology used in this section is consistent with the terminology used in the Terms and Conditions document.

1. Phase I – FY 1995-96 - Service Restoration and Reconfiguration

Preservation of Emergency and Trauma System *(achieved)*

(During the FY 1995-96 fiscal crisis, the County faced the potential collapse of the County's emergency and trauma system, loss of its ambulatory care services delivery system, and a substantial loss in public health services. The announcement of a Presidential commitment for an 1115 Waiver and financial assistance package of $364 million in October 1995 enabled the County to restore many of the service reductions adopted by the Board in August 1995.)

Restorations adopted by the Board, effective October 15, 1995, included funding to restore: (1) the six Comprehensive Health Centers (CHC) to 90% of their pre-cut levels and, (2) the remaining 22 County-operated Health Centers (HC) to 75% of their pre-cut levels. In addition, $20 million was allocated to restore portions of hospital outpatient specialty care services that had sustained cuts approximating 75%. The Board also approved an initial step to a reconfigured delivery system through implementation of the PPP program. Under the first of three requests-for-proposals (RFP) under the PPP Program, six County-operated health centers were privatized, effective November 1, 1995.
Even with the federal financial assistance package, the Department sustained cuts amounting to $285.4 million ($54.9 million in administration, $153.8 in hospital services, $24.6 million in CHC and HC operations, $14.1 million in public health services, and $38.0 million in mental health services), resulting in the layoff of 2,525.

2. Phase II – FY 1996-97 - Year 2 of the Project

The financial package announced by President Clinton in October 1995 covered a one-year period only, i.e., FY 1995-96; as a result, the County was required to renegotiate a financial assistance package for FY 1996-97. The package approved by HCFA for FY 1996-97 included the continuation of three financing elements amounting to $172 million for Year 2. The funds were used primarily to support the provision of ambulatory care services, including the Public/Private Partnership Program.

(During Year 2, the County was required to form an Oversight Committee and develop a detailed Project Management Plan . . . ACHIEVED. These two accomplishments formed the structural plan for the Project.)

Oversight Committee *(compliance)*

As required, an Oversight Committee, comprised of provider representatives, consumer advocates, labor representatives, and key County staff, was established as a formal mechanism to ensure public input and monitoring of the Project. The first meeting was convened in August 1996, and since then, has been generally convened on a quarterly basis. More frequent meetings were scheduled for FY 1998/99. The meetings have served as a forum to provide information to the community and public and to solicit their input. State and federal representatives have consistently attended the meetings.

Project Management Plan *(compliance with document development; continuing progress on program objectives)*

The development of a detailed Project Management Plan (PMP), with all of the required program elements, began in Year 2. As required, the first draft was submitted to HCFA in January 1997. The final document, which included input from community stakeholders, State and HCFA representatives, was formally approved by HCFA on April 1, 1998 (Year 3). The PMP has guided the County in its restructuring effort. The County's progress in meeting the goals in each of the program areas is described in Section III, with a detailed description of actions taken by the County delineated in Appendix I. *(While the County has made significant programmatic progress in certain areas, such as a reduction in the number of budgeted beds, it has not made similar progress in meeting the target for ambulatory care visits and in implementing the information systems projects. Section V, proposed PMP for this extension request, provides details on the County's plan for further work in expanding ambulatory care access and developing its information systems structure.)*[22]

22 A revised PMP action plan was submitted to HCFA in July 1999.

Financial Stability *(reforms needed)* and Re-structuring *(continued progress planned)*

During Year 3 of the Project (FY 1997/98), the County was again faced with the expiration of Project funding. During this third year, the County was successful in convincing HCFA officials of the advantages of extending the financial assistance package through June 30, 2000, rather than negotiating on an annual basis. The financial stability afforded by the three-year assistance package enabled the County to focus, for the *first* time, on programmatic restructuring required by the Terms and Conditions: reengineering, reorganization of the public health organization, and expanding its ambulatory care system. The County's progress in restructuring its system was described in Section III.

Rancho Los Amigos Medical Center (now Rancho Los Amigos National Rehabilitation Center) and High Desert Hospital

The original plans contemplated by the County for its hospital system included privatization of both Rancho Los Amigos *National Rehabilitation Center* (RLANRC) and High Desert Hospital (HDH). During Year 3, the County determined that a proposed seven-year public/private partnership for RLANRC would not yield sufficient savings to offset the financial risks involved in the partnership. This was in part due to savings already achieved by the County in the successful reengineering project begun in FY 1995-96 at RLANRC. In addition, lack of qualified partners for HDH led to revenue-generating options such as providing needed health services to clients of the California Department of Corrections and Immigration and Naturalization Service facilities. These programs have been described in past quarterly reports submitted by the County.

3. Program Design/Operational Plan Requirements

This section describes the County's compliance with Program Design/Operational Plan requirements set forth in the Terms and Conditions.

Population Included under the Project *(compliance)*

As required, eligibility for Medi-Cal has not been expanded under the Project. Those eligible under the Project are individuals with family incomes less than 133 1/3 percent of the Federal Poverty Level. Eligible individuals also include people whose income exceeds $133^{1/3}$%t but under the County's "Ability-to-Pay" program qualify for services.

Outpatient Sampling *(compliance)*

As required, the County submitted to HCFA for review and approval a statistically valid methodology to sample outpatients by July 31, 1997. The purpose of the outpatient sampling is to determine the percentage of non-federally reimbursable aliens and non-indigents (as defined by the Terms and Conditions), which is used to adjust County claims under the indigent care match. (Pending the results of outpatient sampling, County claims under the indigent care match pool have been adjusted by 13.2% and 0%, respectively, as agreed to by HCFA.)

The proposed sampling methodology was approved by HCFA staff on April 1, 1998. As required by the Terms and Conditions, it was implemented by the County commencing with the subsequent quarter, i.e. the July 1, 1998 – September 30, 1998 period. All County-operated sites as well as contract sites providing ambulatory care services are part of the sample. Outpatient sampling is continuing on a quarterly basis unless and until County, State, and Federal representatives agree otherwise.

Delivery System *(compliance)*

The delivery system continues to consist of: DHS Comprehensive Health Centers, Health Centers (excluding clinics that provide predominantly public health services), private contract clinics that provide ambulatory care services to the indigent (including General Relief recipients), mental health clinics operated by the County DMH, private contract mental health clinics, County-operated hospitals, and the Community Health Plan.

Average Waiting Time Reports *(partial compliance; improvements needed and planned)*

Beginning with the sixth quarter of the Project (second quarter of FY 1996-97), the County has been required to submit average clinic appointment waiting times for the following types of services: routine primary care appointments, specialty care appointments, and urgent care and emergency room services. Quarterly reports have been submitted to HCFA as required.

The data provided thus far in the waiting time reports represent clinic appointment availability on the first Thursday of each month, when the data are manually collected. Currently, approximately 650 primary and specialty care clinics (not including public health clinics) are offered by County-operated facilities. The manual collection of appointment waiting times for these clinics is expected to continue until an automated system can be developed to track the time between a request for an appointment and the actual clinic appointment.

Until such complete data are available, County staff have focused on measuring the number of outlier clinics, i.e., the number of clinics exceeding specified waiting time thresholds (e.g., 21 or 45 days). The most recent review of FY

1998-99 second quarter found that 22% and 9% of the clinics overall exceed a 21-day and 45-day appointment waiting period, respectively. Staff is also reviewing those clinics with waiting times listed as zero, to determine whether the zero truly indicates no waiting time or indicates the clinics are not available to additional patients. It should be noted that as part of a teaching hospital system, the capacity of many specialty care clinics at County hospitals, to a large extent, depends on the number of fellows and residents in training for those specific specialties. Nevertheless, the County is devising methodologies to measure capacity and demand for specialty services, using appointment-waiting times as one indicator of access.

4. Administrative Reporting *(compliance - improvements planned)*

The County has complied with the requirement to submit quarterly re-structuring progress reports to HCFA. This requirement commenced with the first quarter of FY 1997-98. The reports are due 60-days following the close of the quarter. However, compliance with the 60-day deadline has been difficult due to lack of timely data and the need to access multiple program and data sources. Additional reporting standards and guidelines have been promulgated to facilitate more timely reporting of both data and program elements by the various program areas.

The County has submitted annual project reports, however, compliance with the 90-day timeline as required by the Terms and Conditions has been difficult due to the lack of timely data. A draft report is due to HCFA 90-days following the close of each fiscal year. The FY 1997-98 report was the most comprehensive report submitted since the beginning of the Project and indicates the County's continued progress toward meeting its waiver commitments.

5. Quality Assurance/Quality Improvement

Public/Private Partnership and General Relief Programs *(partial compliance - improvements needed and planned)*

On an annual basis, all PPP) and GR contract partners receive an administrative review from the County. However, clinical and programmatic reviews have not been conducted to the extent desired. At this time, the County is improving its monitoring instrument to address the need to review both clinical and programmatic issues. In addition, to ensure uniform oversight for the two programs, the administrative responsibility for monitoring was consolidated under the Office of Managed Care in FY 1997/98.

Also, as required, the County's contracts with its PPP and GR partners include specific monitoring provisions which permit County, State, and/or Federal representatives to review the performance of the partner providers. Other contract provisions describe licensure, billing, and reporting requirements and

quality assurance/improvement activities, including the appropriateness and timeliness of services provided.

County-Operated Facilities *(partial compliance - improvements planned)*

The Department is addressing the way it is delivering care at both the inpatient and outpatient levels through the Clinical Resource Management component of reengineering. The Department has developed inpatient clinical pathways for 31 diagnoses. Additionally, disease management protocols for four diseases (pediatric asthma, adult diabetes, HIV/AIDS, and congestive heart failure) have also been developed. Because coordination among the many systems involved in patient care is essential, clinical pathways (at the inpatient level) and disease management (at the outpatient level) will be phased in at County facilities. Selected clinical pathways will be piloted and field-tested at selected inpatient facilities beginning in mid 1999. Disease management for pediatric asthma is also scheduled for implementation on a pilot basis at selected outpatient facilities beginning by mid 1999.

Structural Indicators

All County hospitals and CHCs adhere to accreditation requirements and standards established by the Joint Commission on the Accreditation for Healthcare Organizations (JCAHO). As a result, County hospitals and CHCs have implemented quality improvement and quality assurance programs. Most recently (April 1999), the Northeast Cluster, comprised of the LAC+USC Medical Center and three of the County's six CHCs (El Monte, Hudson, and Roybal), received JCAHO accreditation as a network. Network accreditation is expected to result in a common standard of care for patients throughout the Northeast Cluster.

County-operated HCs are not subject to JCAHO requirements and are exempt from State licensure requirements. Nevertheless, the County is working to extend quality improvement and quality assurance programs at these sites as well.

Using certification as a "community health plan provider" as an indicator, 22% (5) of the 23 County-operated HCs were certified as CHP sites in FY 1994-95. In FY 1998-99, 72% (18) of the 25 County-operated HCs were certified.

Patient Complaints and Patient Satisfaction Surveys *(Compliance - Improvements Planned)*

As required by the Terms and Conditions, the Department collects patient complaint data. Three systems are currently used: (1) CHP customer service system for its plan members and Healthy Families enrollees; (2) DHS' on-site patient advocate/customer relations system for non-managed care patients; and (3) the DHS Information and Referral Line for the general public, PPP and GR

clients. As specified by licensure requirements, CHP uses complaint resolution processes and procedures that comply with Knox-Keene standards governing managed care plans. Although resolution procedures used by DHS facilities for its non-managed care patients vary from those used by CHP, they adhere to standards promulgated by the JCAHO. The most recent complaint data were submitted to HCFA with the County's FY 1997/98 Annual Report. Effective April 1, 1999, DHS facilities will be using a standardized reporting form to summarize complaints received by the facilities for non-managed care patients. The form includes data on the percentage of complaints resolved and specific actions taken to resolve problems identified in the top 10% of the complaints.

Patient satisfaction surveys are conducted annually at DHS facilities and by the CHP for its members. In addition, the County has contracted with the University of California at Los Angeles to conduct a comprehensive patient assessment survey of all patients using DHS facilities or PPP sites. The survey will measure access and quality of care, as well as patient satisfaction. Beginning July 1999, the CHP will begin using an independent National Committee for Quality Assurance (NCQA) affiliated surveyor and instrument to conduct the survey in accordance with the L.A. Care requirements.

New Disciplinary Guidelines for Licensed Medical Professionals

In June 1997, the Department implemented new guidelines to review physician performance. The new guidelines were developed in consultation with the DHS' County Counsel, and lists specific conduct that is subject to disciplinary action. The most notable is in the area of failure to provide care consistent with applicable professional community standards. The guidelines are used in conjunction with the peer review process defined in the Professional Staff Association by-laws of each of the County hospitals. These new guidelines are also applicable to other licensed medical professionals such as nursing staff.

Risk Management

To decrease malpractice claims, specific reporting procedures were adopted in August 1998 to enable DHS facilities to more quickly report, investigate, and take corrective actions related to critical clinical events. Those procedures include definitions of and examples of critical clinical events that require immediate investigation, reporting, and corrective action. In addition, the County Board of Supervisors is in the process of codifying the above procedures.

6. Management Information Systems *(IDC Implemented; Additional Projects Planned)*

Currently, the Department is developing several projects that support data collection at the patient encounter level. One project being implemented is Itemized Data Collection (IDC) at DHS CHCs, HCs, and hospital outpatient facilities. IDC encompasses the use of an encounter form at each facility that

provides necessary system-wide and facility-specific information. The project is designed to identify, code, and store specific information associated with a clinic visit, or inpatient stay (when IDC is expanded to inpatient sites). Information collected includes diagnoses, procedures, ancillaries, pharmaceuticals, and supplies associated with a patient encounter. Other projects, such as a unique patient identifier and the development of a data warehouse/repository, have been delayed due to Y2K priorities, changes in plans, and unresolved funding issues.

7. Performance under Budget Neutrality

See Section E below.

8. Independent Audits and Evaluations

Claims for Federal Financial Participation Funds *(Compliance)*

On an annual basis, the County has complied with the requirement that billings for federal financial participation (FFP) funds, under the indigent care match, are certified by an independent accounting firm. The most recent certification, for FY 1997-98, was submitted to the State in March 1999.

Project Evaluation *(Compliance)*

On the programmatic side, the Urban Institute has been retained by HCFA to perform a case study and evaluation of the Project.

Also, State representatives have made periodic site visits to the County. On their most recent visit in May 1999, Region IX and central HCFA staff accompanied State representatives. Following each visit, State staff have provided suggestions and recommendations to the County.

C. Evidence of Beneficiary Satisfaction

Both the monitoring and evaluation activities have been key in assessing the Department's restructuring impact on patients and its blended health care delivery system (see Monitoring and Evaluation section for additional details). Based on initial patient satisfaction surveys, patients seemed to prefer services from PPP sites to DHS health centers. However, focus groups conducted at both PPP and DHS sites show that patients were not able to distinguish the difference between the two when seeking care.

Some of the barriers to care identified from the initial patient satisfaction surveys included inability to pay (providers, apparently, imposed non-sanctioned charges), geographical restrictions imposed by some PPP sites (i.e., providers restricted services to residents within its service area or SPA) and transportation

difficulties. An additional barrier, as reported by survey participants, was long waiting times to see a doctor once the patient presented for a clinic appointment. See below for a discussion on the patient focus groups.

Patient Assessment Survey

This face-to-face survey assesses patient satisfaction with services received as well as patient perception of health care access at County-funded ambulatory care sites. The survey instrument is based on the Consumer Assessment of Health Plans (CAHPS) questionnaire, which was designed to help consumers identify health care plans and services that best fit their needs. Patient interviews are now underway and are expected to be completed by June 1999. Data analysis is expected to be completed by September 1999, with the report released in early October 1999.

Patient Focus Groups

With the assistance of the San Fernando Valley Neighborhood Legal Services ("SFVNLS") and the USC School of Public Administration (USC), patient focus groups were conducted at 10 primary care sites. SFVNLS and USC determined the methodology.

Two of the 10 sites were located at County hospitals, and the others were either at PPP or HC sites. The purpose of the focus groups was to identify barriers to care and improvements in service delivery and access, and to assess patients' experiences in using ambulatory care services. Clinic staff selected the majority of the 44 participants. Some of the participants were recruited directly from waiting areas or patient education classes, and only patients with one of eight ambulatory care sensitive conditions were included. All but one of the participants identified the site as their regular source of care.

The preliminary findings demonstrated that participants generally chose the service site by its geographic location (e.g., proximity to home). Findings also indicated that participants were usually able to receive the services they needed. Most participants with chronic illnesses made use of the appointment system for return appointments needed on a regular basis. Waiting times, other than for regularly scheduled appointments, varied from two weeks to three-months. Those faced with a long appointment waiting time elected to walk in. Nearly all participants received lab tests and prescriptions. About two-thirds (19) of participants required referrals to County hospitals for specialty services.

Financial barriers and long waiting times contributed to lower utilization of specialty services. Overall, the majority of the participants were satisfied with the services provided at the site.[23]

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23 Some of the barriers identified when accessing PPP providers corroborate the findings of the initial assessment of the first six PPP providers conducted in FY 1996-97. As indicated

Overall, the evidence from the surveys and focus groups suggests that access points to primary care have expanded considerably, but actual access to care increased only modestly. While the number of PPP providers has tripled since FY 1995-96, utilization has increased by only 50% of the projected levels. Further, the PPP Program has reached only about 5% of the indigent populations in the county (this figure excludes the number of indigent seen at DHS facilities).

Complaints & Grievances

As described previously, patient complaints are collected via three distinct systems within the Department:

- CHP Customer Service System for Plan members and Health Families enrollees;
- DHS On-Site Patient Advocate/Customer Relations Programs;
- Health Services Information Line (Information and Referral Line) for the public, PPP, and GR clients.

The CHP handles patient complaints and grievances in accordance with Knox-Keene licensing requirements. The CHP Customer Service System collects information on a monthly basis and provides a report to L.A. Care.

DHS facilities utilize information from on-site patient advocates and customer relations representatives to identify areas in need of improvement. Facilities may include such deficiencies in their quality improvement plan. Resolution of actual specific patients' complaints is the responsibility of facility administrators.

The Health Services Information Unit, a toll-free number, receives inquiries and complaints regarding DHS and non-DHS facilities. The information received is forwarded to the appropriate DHS department or other agency for necessary resolution. The majority of the inquiries received are for general information.

DHS will implement a standardized reporting form to summarize complaints received by the facilities for its non-managed care patients during the fourth quarter of FY 1998-99. A standardized reporting form will facilitate the aggregation of complaint data on a Department-wide basis.

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above, appointment scheduling wait times for laboratory and pharmacy services, and off-site laboratory and pharmacy services (when on-site services were not available) represented significant issues for PPP patients.

D. Documentation of Adequacy and Effectiveness of Service Delivery System

As presented earlier, the blended public/private system is expected to generate 2.76 million visits by June 30, 1999. Table 3 below shows the distribution of ambulatory care sites and projected patient volume based on actual FY 1997-98 visit volume.

A map showing the geographic distribution of primary care providers (DHS and PPP) is included as Appendix II. Based on recent analysis, DHS found that primary care sites might need to be added in some service planning areas to allow patients better access to providers closer to where they live. In other cases, improving transportation options may facilitate access for patients who require services offered at a more distant facility.

Table 3. Ambulatory Care Site Distribution

I. Number of County and P/PP Ambulatory Care Service Locations within Los Angeles County's Service Planning Areas (SPA)

SPA #	SPA Name	DHS Hospitals	CHCs		HCs		Co-Locations*		P/PP	General Relief	DMH	ADPA Locations	HIV/AIDS**
			Personal Health	Public Health	Personal Health	Public Health	Personal Health	Public Health					
1	Antelope Valley	1			2	1			1	1	3	11	6
2	San Fernando Valley	1	1	1	6	3			17	2	26	52	44
3	San Gabriel Valley		1		2	1	1	1	15	3	21	65	29
4	Metro	1				1		1	31	7	20	60	135
5	West							1	3	3	16	25	26
6	South	1	2	1	2	3		1	17	6	13	63	46
7	East	1	1	1	5	3			12	6	19	60	35
8	South Bay	1	1		3	3		1	22	4	19	65	70
	County Total	6	6	3	20	15	1	5	118	32	137	401	420

II. County & P/PP Ambulatory Care Service Locations within Los Angeles County's Service Planning Areas (SPA) & Visits

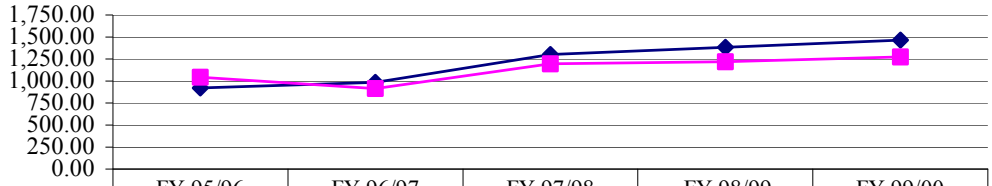
SPA #	SPA Name	DHS Hospitals	CHCs		HCs		Co-Locations*		P/PP	General Relief	DMH	ADPA Locations	HIV/AIDS**
			Personal Health	Public Health	Personal Health	Public Health	Personal Health	Public Health					
1	Antelope Valley	48,139			27,134	11,928			9,194	4,992	46,444	88,482	NA
2	San Fernando Valley	107,049	24,763	9,976	65,368	46,496			57,537	16,089	278,691	247,193	NA
3	San Gabriel Valley		101,693		32,586	28,080	17,079	25,939	31,254	6,155	249,399	215,462	NA
4	Metro	508,809				27,605		28,787	91,150	62,994	108,868	342,382	NA
5	West							1,087	21,686	4,243	86,634	178,850	NA
6	South	191,135	311,966	6,096	31,488	42,302		5,352	22,269	5,353	115,836	409,955	NA
7	East	55,385	130,032	4,148	58,248	36,800			15,903	2,704	142,624	274,314	NA
8	South Bay	243,853	36,921		55,506	35,352		27,054	25,929		191,133	380,412	NA
	County Total	1,154,370	605,375	20,220	270,330	228,563	17,079	88,219	274,922	102,530	1,219,629	2,137,050	544,517

* DHS facility operated by a PPP provider, delivering primary care services; DHS delivers public health services only.
** Shows the geographic distribution of County and contract providers. Locations may serve patients from one or more SPAs or countywide.

E. Compliance With Budget Neutrality Cap

In 1998, in accordance with the Special Terms and Conditions, the County and State proposed adjustments in two revenue categories in calculating the budget neutrality limit governing the Project. The two revenue categories are: (1) health plan revenues received by the County from Medi-Cal prepaid health plans in the base year of the Project (SFY 1994/95) and (2) disproportionate share hospital payments for SFYs 1997/98 and 1998/99. The revised budget neutrality limit was approved by HCFA in April 1999. Based on HCFA's approval, the County's performance under the revised budget neutrality limit is illustrated in Figure 16 below. On a cumulative basis, based on projections as of April 1999, the County has "room" amounting to $408 million by June 30, 2000. Appendix III portrays the projected cumulative federal expenditures.

Figure 16: Performance Under Budget Neutrality
($ in Millions)

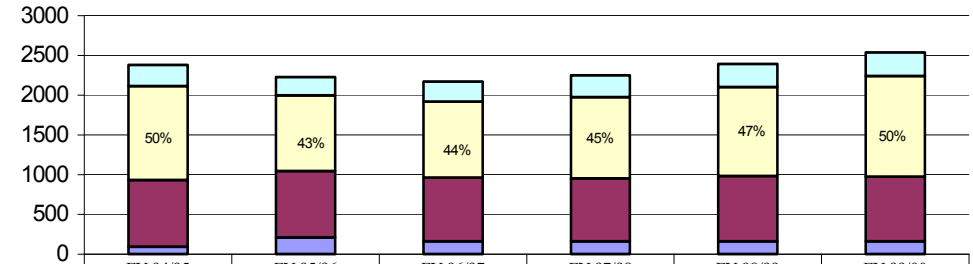


	FY 95/96	FY 96/97	FY 97/98	FY 98/99	FY 99/00
Federal Revenue Ceiling	$920.10	$984.00	$1,299.60	$1,381.40	$1,465.70
Federal Revenues Received	$1,044.60	$912.60	$1,194.20	$1,216.90	$1,274.50

Assumes OBRA '93 @ 175%
Source : DHS Finance, March 17, 1999.

In addition, the County's reliance on federal funding has decreased since FY 1994-95, at which time Federal funds comprised 50% of the Department's operating budget (Figure 17). Since then, that percentage has decreased to 45% in FY 1997-98. Re-stated in absolute dollar amounts, Federal funding decreased from $1.185 billion to $1.021 billion, a 13.9% decrease. Based on April 1999 projections, it is anticipated that Federal revenues will increase in FY 1998-99, comprising 47% of the Department's budget.

Figure 17: Trend of Major Funding Components
($ in Millions)



	FY 94/95	FY 95/96	FY 96/97	FY 97/98	FY 98/99	FY 99/00
Other	266	230	252	273	294	297
Federal	1,185	951	958	1,021	1,116	1,267
State	837	834	802	795	824	813
County	92	209	159	159	159	159

Source: DHS Finance, April 19, 1999.

F. Monitoring and Evaluation

The County proposed drastic, system-wide changes under the Project to help stabilize its ailing health care system while initiating a unique restructuring process. This section summarizes the evaluation efforts that assess main areas of change. Although not all evaluation activities are complete, preliminary results indicate that the Department is heading in the right direction.

During the first three and a half years of the Project, DHS monitored new activities and programs and evaluated the effects of changing its health care delivery system. The following provides the status of various ongoing evaluation projects and summarizes future evaluation efforts.

1. Monitoring

Initial PPP program-monitoring activities consisted of assessing performance related to regulations, standards and contract compliance.

To implement the Department's commitment of a single standard of care across its public-private provider network, the Department consolidated the administrative responsibility for the PPP and GR programs under the Office of Managed Care (OMC) in October 1997. Since OMC also administers the CHP, the Department also incorporated applicable managed care standards and principles in its administration of the PPP and GR programs to ensure consistent system-wide quality assurance and quality improvement programs.

In addition, in October 1997, the County implemented the payment of a case-rate fee to the PPP partners for the case management of designated ambulatory care sensitive (ACS) conditions. Case management protocols have been developed for ACS conditions which all PPP providers are required to implement by March 1, 1999.

However, to date, monitoring has not been rigorously conducted because of inadequate staffing and the complexity associated with the development of a uniform monitoring tool and procedures.

Currently, the PPP and GR programs, CHP and County CHCs and HCs are uniformly monitored using State managed care standards for Medi-Cal managed care plans/providers. Using managed care evaluation tools for many of these providers, particularly County health facilities which have been exempt from many of these types of requirements, is a significant step in the direction toward achieving system-wide quality of care.

Additionally, a case management review was initiated at PPP sites to ensure a well-coordinated, systematic and comprehensive type of health care delivery, especially for ACS conditions. The case management review tool and regular chart reviews will be combined to increase the effectiveness of the monitoring process and improve overall quality of care.

Creating the PPP program and enhancing primary care services at County-operated health centers has been a necessary and viable step in the restructuring process. More patients are returning to County CHCs and HCs, and PPP visits for medically indigent patients have increased fivefold since the first year of the PPP program. Overall, monitoring efforts at these sites should help ensure quality standards so patients will return for routine care and ultimately not come to County emergency rooms and hospitals for inappropriate care.[24,25]

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24 Kusserow, K. (1992). *Controlling Emergency Department Use: State Medicaid Reports*. Washington, DC: US Department of Health and Human Services. This study found that hospitals are used by many low income and uninsured people in the US often because these people do not have access to physicians or clinics. In another study, public hospital emergency room patients showed that nearly three-quarters of all emergency room patients have health conditions that do not warrant the use of emergency services (Grumach, K. (1994). *American Journal of Public Health, 84*(1), 123.).

25 In Los Angeles County, an estimated 5% of working age adults rely on hospital outpatient clinics as their regular provider while about 2% rely on emergency rooms. Of these, nearly three-quarters are either uninsured or enrolled in Medi-Cal (L.A. County Health Survey, 1997).

2. Evaluation

Program evaluation involved studies that addressed the overall impact of the Project on its many stakeholders including the County, private providers, insurers, uninsured population, and community. Specifically, studies have begun to address whether the County's restructuring has resulted in decreased hospitalizations due to increasing comprehensive and quality primary and preventive care at the community level. Without direct empirical data, the expectation is that further evaluations will clarify the effect of system changes underway.

As the Project moves into its final year, many questions remain regarding the County's success in restructuring the safety net. Will the increase in primary access sites actually increase the number of patients receiving primary care services? Additionally, will the increase in primary care sites and services have an impact on the level of inappropriate services provided at County hospitals' emergency rooms? Moreover, as primary care services increase, will the County be prepared to handle additional specialty care needs? How will the new medical school affiliation agreements affect the safety net system? Are the linkages between the private and public health system stronger?

Los Angeles County Health Survey

The LA County Health Survey is a population-based survey designed to examine important health indicators of adults and children living in Los Angeles County. To date, three survey publications regarding uninsured populations in the County have been published. Additional publications will be published in the future. The survey results have been used widely throughout the Department and community, especially for service-delivery planning. Community-based planning meetings were conducted throughout the County to ensure community input.

The survey's findings have established some baselines for health status indicators, which will be used to assess the progress of the Department toward assuring health access for the medically indigent and other uninsured populations.

Clinic Baseline (Provider) Survey

This survey assesses the impact of the Project on the operations of PPP and County health center sites. The survey was designed to compare provider profiles before and after the commencement of the Project. A follow-up survey will be administered in July 1999, with a report released by November 1999.

Overall, survey findings show the blended public/private system is increasing access to care for the medically indigent in a number of ways. Specifically, the findings show the following:

- Twenty-three percent increase in the total number of clinics providing general adult services;

- Thirty-one percent increase in pediatric services;

- Thirty-nine percent increase in total sites offering on-site specialty services;

- Provision of case management, health education, and follow-up appointment procedures; and

- Seventy-six percent of PPP and GR providers utilized County referral centers for specialty care referrals.

VII. PROPOSED AMENDMENTS

This section contains the three proposed amendments and one additional proposal to the Waiver. These are summarized below, with the complete details contained in the corresponding Exhibits.

Healthy Students Partnership amendment to support school-based and school-linked services with the Los Angeles Unified School District and other county school districts, at an estimated value of $85 million per year. The primary goals of this proposal are to: (1) expand ambulatory care services targeting uninsured school-age children and youth for a projected 500,000 visits by 2005; and (2) link schools with the blended public and private health care delivery system, DHS ambulatory care facilities and partner clinics. This amendment would provide for more effective outreach, coordination of care, health promotion, and enrollment in Medi-Cal and Healthy Families programs. Exhibit I provides a detailed executive summary describing the key elements of the HSP proposal. The State submitted the complete proposal to HCFA in April 1999.

Health Care Workforce Retraining amendment to fund a multi-year workforce retraining project, based on the recommendations by the *President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry* co-chaired by Madam Secretaries Donna Shalala and Alexis Herman, at an estimated $20 million per year for three years. This project's goals are to: (1) design and implement workforce training and retraining programs for an estimated 2,400 workers at-risk of being impacted by restructuring; and (2) retrain and transition all 23,000 employees towards a managed care delivery system guided by public health principles and supported by a strategic alliance between management and SEIU Local 660. Exhibit II provides detailed information.

Federal Matching Funds amendment for additional FFP to cover uncompensated costs incurred by County-run hospitals for services to medically indigent patients, at an estimated value of $50 million per year. This amendment would: (1) support the changing role of public hospitals in the coordination and provision of 250,000 hospital-based specialty care visits; and (2) reduce the patient waiting times for specialty care services to less than 21 days for services that are in high demand as a result of expanding access to primary care. Exhibit III provides detailed information.

County Restructuring/Stabilization proposal to support a viable and restructured safety net health system in the long-term. Exhibit IV provides detailed information.